STAGE II, Inc. Anesthesia Services Patient Questionnaire

NAME: ______________________ **AGE:** ________ ☐MALE ☐ FEMALE

HEIGHT: __________ **WEIGHT:** ____________ **HOME TEL#** ____________________

PRIMARY PHYSICIAN: ________________________ **SPECIALIST:** ____________________

	YES	NO
Have you or any blood relative ever had a reaction to anesthesia or blood products?	☐	☐
☐Nausea/ Vomiting ☐ Other (Specify) ____________________________		
If Female, could you be pregnant? Last Menstrual Period: ________________	☐	☐
Can you walk a mile without shortness of breath/ chest tightness?	☐	☐
Can you walk up two flights of stairs without shortness of breath/ chest tightness?	☐	☐
Do you get shortness of breath/ cheat tightness during minimal exertion?	☐	☐

List any prior surgeries and dates: ____

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HEART	YES	NO	If yes, explain
High Blood Pressure	☐	☐	Treatment? ______________________
Chest Pain (Angina)	☐	☐	Changed Recently? ___________________
Heart Attack (MI)	☐	☐	When? ________ Hospitalized? __________
Irregular Heart Rhythm	☐	☐	Specify: ____________________________
Heart Valve Disease	☐	☐	Specify/ Symptoms: ____________________
Congestive Heart Failure (CHF)	☐	☐	Last Symptoms: ______________________
Vascular Disease	☐	☐	Medications: _________________________

LUNGS			
COPD (Asthma, Chronic Bronchitis Emphysema)	☐	☐	Specify: ______________________________ Have you ever required ER visit? ICU? _______
Sleep Apnea	☐	☐	Symptoms: _________________ CPAP: _____
Other Lung Disorder	☐	☐	Specify: ________________________________
Do you smoke?	☐	☐	How much/ how long: ______________________

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BRAIN

Stroke and/or weakness/ numbness	☐	☐	Specify: ____________________
Seizure/ Convulsions	☐	☐	Last Episode: ____________________
Nerve/ Muscle Disease	☐	☐	Specify: ____________________

Do you have:

Diabetes, thyroid, or kidney problems	☐	☐	Specify: ____________________
Liver disease, hepatitis, jaundice	☐	☐	Specify: ____________________
Bleeding disorder	☐	☐	Specify: ____________________
Acid Reflux/ Hiatal Hernia/ heartburn	☐	☐	Specify: ____________________

List all Medications and the time of the last dose taken prior to surgery ;

Are you allergic to any medications/ other substances? If so, please list: ____________________

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Please describe any problems or questions you may have that are not covered on this questionnaire. ____________

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Patient (Parent/ Guardian) Signature: ____________________ Date: ____________