IRELAND GROVE
CENTER FOR SURGERY
3801 IRELAND GROVE RD • BLOOMINGTON, IL 61704 • PH: (309) 664-0101 • FAX (309) 664-1010

PATIENT HISTORY/PRE-ANESTHESIA QUESTIONNAIRE

Name_____ DOB_____Age____ Ht._____ft_____in Wt._____BMI _____
Surgeon_____Date of surgery_____ Medical doctor_____☐NONE
Home phone_____ Work phone_____ Cell phone_____
May we leave a message at these numbers to discuss your care? ☐ No ☐ Yes – Specify_____
DO YOU HAVE ANY ALLERGIES? ☐ Yes ☐ No

ALLERGIC TO:	**REACTION:**	Please list all **PREVIOUS SURGERIES** and year

Have you or any family members had complications with anesthesia? ☐ Yes ☐ No ☐ N/A
If yes, please specify who and what type of complication_____

FEMALE PATIENTS
Last menstrual period_____
☐ Post-menopausal greater than 2 years
☐ Hysterectomy ☐ Tubal ligation ☐ Lactating

PEDIATRIC PATIENTS (children under 12)
Premature? ☐ Yes ☐ No
If yes, estimated gestational age (_____weeks at birth)
Immunizations up to date? ☐ Yes ☐ No

MEDICAL HISTORY
Do you now have or have you ever had any of the following? **PLEASE MARK THE APPROPRIATE BOXES FOR "YES" ANSWERS.**

☐ High Blood Pressure
☐ Heart Murmur/Leaky Heart Valve
☐ Congestive Heart Failure
☐ Heart Attack
☐ Chest Pain/Angina
☐ Coronary Artery Disease
☐ Mitral Valve Prolapse
☐ Fast or Irregular Heartbeat
☐ Pacemaker/Defibrillator
☐ Asthma
☐ Frequent Shortness of Breath
☐ Heavy Snoring
☐ Recent Respiratory Infection
☐ Emphysema/COPD
☐ Blood Clots
☐ Bleeding Problems
☐ Sleep Apnea/CPAP
☐ Chronic Cough
☐ Tuberculosis
☐ Seizure Disorder
☐ Stroke/TIA
☐ Parkinson's Disease
☐ Multiple Sclerosis
☐ Motion Sickness/PONV
☐ Myasthenia Gravis
☐ Depression/Anxiety
☐ Mental Health Issues_____
☐ Liver Disease/Jaundice
☐ Hepatitis-Type? _____
☐ Hiatal Hernia/Ulcer
☐ Acid Reflux/Heartburn
☐ Blood Disease/Anemia
☐ Diabetes Type_____
☐ TMJ/Jaw Problems
☐ Rheumatoid Arthritis
☐ Neck Problems
☐ Cancer-Type? _____
☐ Kidney Disease
☐ Antibiotic Resistant Infection (MRSA/VRE)
☐ Implants/Prosthesis
☐ Skin Conditions (Rash/Psoriasis/Eczema)
☐ Shingles-When? _____
☐ Other Medical Condition
_____
_____

Comments_____

History of smoking? ☐ No ☐ Yes How much daily?_____ How many years?_____ Quit?_____When?_____
Do you drink alcohol? ☐ No ☐ Yes ☐ Daily ☐ Weekly
Do you use recreational drugs? ☐ No ☐ Yes What type and how often?_____
Do you have dentures? ☐ No ☐ Yes Please circle FULL PARTIAL UPPER LOWER
Do you have capped front teeth? ☐ No ☐ Yes
Have you been hospitalized in the past 3 months? ☐ No ☐ Yes Reason?_____

You will meet with the anesthesiologist the day of surgery. Do you need an appointment to meet an anesthesiologist prior to the day of surgery? ☐ Yes ☐ No

LEARNING NEEDS

☐ NONE ☐ Medication ☐ Pain Management ☐ Other_____
☐ Procedure/Surgery ☐ Wound Care ☐ Safety _____
_____

BARRIERS

☐ NONE ☐ Physical Limitations ☐ Language/Speech ☐ Other_____
☐ Fear/Anxiety/Emotional ☐ Visual Limitations ☐ Hearing Limitations _____
_____

Who completed this form? ☐ Self ☐ Other_____

PATIENT / RESPONSIBLE ADULT SIGNATURE_____DATE_____

REMAINDER OF FORM FOR STAFF USE ONLY

NURSE REVIEW

Surgery #1 Reviewed by RN_____Date_____

Surgery #2 Reviewed by RN_____Date_____

Surgery #3 Reviewed by RN_____Date_____

ANESTHESIA NOTES

Surgery #1
CV_____
Lungs: ☐ CTA Other:_____
Airway:_____

Teeth:_____
Diagnostic Studies
EKG: ☐ WNL Other:_____
LABS: ☐ WNL
Other:_____
_____

ASA PHYSICAL STATUS: 1 2 3 4 E
Anesthetic Plan: ☐ GA ☐ MAC ☐ IVB ☐ LOCAL
☐ Peripheral Block for Pain Control

_____MD/DO
Date_____ Time_____

Surgery #2
CV_____
Lungs: ☐ CTA Other:_____
Airway:_____

Teeth:_____
Diagnostic Studies
EKG: ☐ WNL Other:_____
LABS: ☐ WNL
Other:_____
_____

ASA PHYSICAL STATUS: 1 2 3 4 E
Anesthetic Plan: ☐ GA ☐ MAC ☐ IVB ☐ LOCAL
☐ Peripheral Block for Pain Control

_____MD/DO
Date_____ Time_____

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MEDICATION LIST

Name_____ Birth Date_____ Pharmacy_____

Please read the following instructions carefully before completing this medication list.
1. Please list all the medications you are currently taking, including over-the-counter medications and herbal supplements.
2. Please include medication dose and how often you take it and if it was stopped for the planned surgery.
3. All medications must be written on this form. **"See attached list" is unacceptable** and you will be required to fill out this form before your surgery will be completed.

MEDICATION	DOSE	TIME TAKEN AM / PM	STOPPED FOR SURGERY	RESUME	DO NOT RESUME	PHYSICIAN COMMENTS
Example: Aspirin	81 mg	AM	X			

☐ **NO NEW MEDICATIONS PRESCRIBED TODAY**

Medications Prescribed Today	Directions For Use

☐ Resume all home medications Date_____ RN Signature_____

☐ Resume all home medications Date_____ RN Signature_____

☐ Copy of Medication List given to patient/responsible adult and instructed to take this list to all future doctor appointments.

RN Signature_____ Date_____

Surgery #1 **MD Signature**_____ Date_____

Surgery #2 **MD Signature**_____ Date_____