To be filled out by patient or patient's family

Patient's Name: ____________________________________
Age: ________ DOB_____________ Weight:______ Sex: M / F

Name of your child's parent or legal guardian or who will accompany you or your child to and from the surgery center and will be available during the surgery and postoperatively: _______________________________________
Phone number: ___________________ Phone (on day of surgery e.g.: cell)________________________
Reason for Surgery: ____

Check the appropriate box. If "yes" then specify.

Yes	No		Comments
❑	❑	Any previous surgeries?	
❑	❑	Any problems with anesthesia? Any blood relatives of the patient have problems with anesthesia, including malignant hyperthermia?	
❑	❑	Any medical problems presently or in the past?	
❑	❑	Any medications (prescription & non-prescription) now or recently taken?	
❑	❑	Any use of steroids (such as cortisone or prednisone) within the last year, including breathing treatments?	
❑	❑	Any medical devices or machines used?	
❑	❑	Any allergies? (including medication or latex reactions)	
❑	❑	Any problems at birth? (prematurity, oxygen or machine ventilation) Specify:	
❑	❑	Any exposure to cigarette smoke? Drugs?	
❑	❑	Any recent colds or respiratory infections? Cough with sputum? COVID-19?	
❑	❑	Any difficulty breathing, such as wheezing or asthma?	
❑	❑	Any problems with snoring or stopping breathing during sleep? Sleep Apnea? CPAP?	
❑	❑	Any problems with shortness of breath or excessive fatigue with physical exercise- playing, walking, stairs or running? "Turning blue"	
❑	❑	Any history of heart problems? (murmur, irregular)	
❑	❑	Any history of seizures, epilepsy, or passing out?	
❑	❑	Any muscle weakness, myopathy, or muscular dystrophy?	
❑	❑	Any other physics disabilities?	
❑	❑	Any history of diabetes? Hormonal problems?	
❑	❑	Any bleeding or clotting problems with child or any blood relative?	
❑	❑	Any heartburn or acid reflux of the stomach?	
❑	❑	Any history of jaundice or hepatitis?	
❑	❑	Any kidney problems?	
❑	❑	Any loose, chipped or broken teeth?	
❑	❑	Any other medical problems?	
❑	❑	Any special concerns about you or your child?	
❑	❑	Do you or your child have any special concerns about anesthesia?	

This information is true and accurate to the best of my knowledge.

Patient/Parent/Guardian signature: ____Date: ___________________

TIVACARE ANESTHESIA

Adult/Pediatric Anesthesia Questionnaire

Rev. 07/2021