Chicago Prostate Center
PRE - ANESTHESIA QUESTIONNAIRE

Patient Name: _____ Date: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION:

AGE: _____ HEIGHT: _____ WEIGHT: _____

PRIMARY PHYSICIAN: _____ Phone #: _____

CARDIOLOGIST: _____Phone #: _____

	PLEASE CHECK	
ALLERGY TO LATEX OR RUBBER PRODUCTS	NO☐	YES☐
FOOD ALLERGIES	NO☐	YES☐
➢ IF YES, PLEASE LIST: _____		
MEDICATION ALLERGIES	NO☐	YES☐
➢ IF YES, PLEASE LIST: _____		

MEDICAL HISTORY: Please list your medical history: _____

PLEASE CHECK

➢ PRIOR HEART ATTACK?	NO☐	YES☐
➢ PRIOR STROKE?	NO☐	YES☐
➢ HEART OR BYPASS SURGERY?	NO☐	YES☐
➢ IF YES, WHEN & WHERE? _____		
➢ ANGIOGRAM OR ANGIOPLASTY?	NO☐	YES☐
➢ IF YES, WHEN & WHERE? _____		
➢ CONGESTIVE HEART FAILURE?	NO☐	YES☐
➢ HYPERTENSION (HIGH BLOOD PRESSURE)	NO☐	YES☐

- ➢ IF YES: HOW LONG? _____

- ➢ IRREGULAR HEART BEATS? NO☐ YES☐

- ➢ CHEST PAIN / ANGINA? NO☐ YES☐

- ➢ SHORTNESS OF BREATH? NO☐ YES☐

- ➢ HAVE YOU EVER HAD A STRESS TEST? (treadmill) NO☐ YES☐

  - ➢ IF YES: WHEN & WHERE? _____

  - ➢ WHAT TYPE? _____

- ➢ HAVE YOU EVER HAD AN ECHOCARDIOGRAM? NO☐ YES☐
(Ultrasound movements of the heart)

  - ➢ IF YES: WHEN & WHERE? _____

- ➢ ALCOHOL? NO☐ YES☐

  - ➢ IF YES, HOW MANY DRINKS / DAY? _____
  - ➢ HOW MANY TIMES/WEEK? _____

- ➢ SMOKER? NO☐ YES☐

  - ➢ IF YES, HOW MANY PACKS / DAY? _____

  - ➢ HOW MANY YEARS? _____

- ➢ ASTHMA? NO☐ YES☐

- ➢ RECENT BRONCHITIS OR PNEUMONIA? NO☐ YES☐

- ➢ CHRONIC PULMONARY DISEASE NO☐ YES☐
OR LUNG PROBLEMS?

- ➢ SLEEP APNEA? NO☐ YES☐
- ➢

  - ➢ If yes, do you use c-pap NO☐ YES☐

- ➢ HIATAL HERNIA? NO☐ YES☐

- ➢ HEARTBURN OR ACID REFLUX? NO☐ YES☐

- IF YES, HOW FREQUENT? _____

- BLEEDING DISORDERS? NO☐ YES☐
- BLOOD THINNING MEDICATIONS? NO☐ YES☐
- THYROID DISEASE? NO☐ YES☐
- DIABETES? NO☐ YES☐
  - IF YES: HOW LONG? _____
  - CONTROLLED WITH: ☐INSULIN ☐ORAL PILLS ☐DIET
- PREVIOUS SURGERIES? NO☐ YES☐
  - IF YES, LIST: _____
- PRIOR ANESTHETIC PROBLEMS? NO☐ YES☐
  - IF YES, EXPLAIN: _____
- ANY FAMILY HISTORY OF ANESTHESIA DIFFICULTIES? NO☐ YES☐
- LIMITATION IN NECK MOBILITY? NO☐ YES☐
- DO YOU HAVE LOOSE OR CHIPPED TEETH? NO☐ YES☐
- DO YOU HAVE DENTURES OR PARTIALS? NO☐ YES☐
- DO YOU EXERCISE ON A REGULAR BASIS? NO☐ YES☐
  - IF YES, WHAT KIND? _____
  - HOW OFTEN DO YOU EXERCISE? _____

ARE YOU ABLE TO WALK UP 2 FLIGHTS OF STAIRS WITHOUT DIFFICULTY? NO☐ YES☐

- IF NO, IS IT DUE TO: ☐ ARTHRITIS ☐ SHORTNESS OF BREATH

☐ CHEST PAIN OTHER: _____

- LIST ALL THE MEDICATIONS THAT YOU ARE CURRENTLY TAKING ON THE MEDICATION LIST GIVEN TO YOU. _____

FOR OFFICE USE ONLY:

INFORMATION REVIEWED BY: _____MD DATE: _____

Rev 01/09