

## DATA COLLECTION QUESTIONNAIRE

**PLEASE USE BLUE OR BLACK INK**

History	Patient	Family
1. Heart trouble (Heart attack, chest pain, fast or skipped heartbeat)	yes no	yes no
2. Fainting or blackout spells	yes no	yes no
3. High Blood Pressure	yes no	yes no
4. <b>Pacemaker</b>	yes no	yes no
5. Shortness of breath	yes no	yes no
6. Stroke	yes no	yes no
7. Abnormal EKG	yes no	yes no
8. <b>Asthma</b>	yes no	yes no
9. Bronchitis, emphysema or other lung disease	yes no	yes no
10. <b>Sleep apnea</b>	yes no	yes no
a. <input type="checkbox"/> Cpap    b. <input type="checkbox"/> Bipap		
11. Abnormal Chest Xray	yes no	yes no
12. Exposure to Tuberculosis	yes no	yes no
Do you have any of these symptoms:		
<input type="checkbox"/> cough <input type="checkbox"/> bloody sputum <input type="checkbox"/> fever <input type="checkbox"/> night sweats		
<input type="checkbox"/> unexplained weight loss <input type="checkbox"/> No symptoms		
13. Epilepsy or Seizures	yes no	yes no
14. Psychological (dementia, depression, suicidal tendencies, etc.)	yes no	yes no
15. <b>Hepatitis</b> , Mononucleosis, Jaundice	yes no	yes no
16. A positive HIV/Aids blood test	yes no	yes no
17. MRSA	yes no	yes no
18. History of Sickle Cell Trait or disease	yes no	yes no
19. Blood Transfusion	yes no	yes no
20. Abnormal bleeding tendencies	yes no	yes no
21. Anticoagulant therapy (blood thinners)	yes no	yes no
22. Blood Vessel disease (phlebitis, etc.)	yes no	yes no
23. Blood disease (anemia, etc.)	yes no	yes no
24. Motion Sickness	yes no	yes no
25. Heartburn or Hiatal Hernia (reflux)	yes no	yes no
26. Glaucoma	yes no	yes no
27. <b>Kidney Disease</b>	yes no	yes no
28. Fracture of facial bones	yes no	yes no
29. Fracture of neck or back	yes no	yes no
30. Muscle weakness	yes no	yes no
31. Paralysis	yes no	yes no
32. <b>Diabetes</b>	yes no	yes no
33. Cancer	yes no	yes no
34. Restricted Extremity Use (cancer surgery, RSD, etc.)	yes no	yes no
35. Latex sensitivity or allergy	yes no	yes no
36. Other medical Illness	yes no	yes no

**Do You:**

1. Have false or loose teeth?	yes no
2. Have dental caps or bridges?	yes no
3. Have any body piercings?	yes no
4. Wear contact lenses?	yes no
5. Smoking history? <input type="checkbox"/> How many packs/day? _____	yes no
How many years? _____ When quit? _____	
6. Use alcoholic beverages?	yes no
7. Have a history of substance abuse?	yes no
8. Have your own blood donated?	yes no
9. Object to a blood transfusion?	yes no

**If Female of child bearing age:**

1. Is there any possibility that you could be pregnant?	N/A	yes no
2. Are you currently lactating?		yes no
Date of last menstrual cycle: _____		
Pregnancy test results: _____ Date / Time: _____		

List previous surgeries (type and date) attach additional sheet if necessary:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Previous Anesthetic History:**

- Date of last anesthesia: \_\_\_\_\_
- Any abnormal reactions? Yes No
- Relatives with abnormal reactions to anesthesia: Yes No
- Comments: \_\_\_\_\_
- Have any problems to discuss with the anesthesiologist? Yes No

Time of last food or drink: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date / Time:** \_\_\_\_\_

Vital Signs: B / P: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ Temp: \_\_\_\_\_ O2 Sat: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date / Time: \_\_\_\_\_ Signature: \_\_\_\_\_

**FOR ANESTHESIOLOGIST / PAIN MANAGEMENT USE**

**Anesthesia Evaluation**

Mallampati's Classification:  Class I  Class II  Class III  Class IV

Exam: Airway \_\_\_\_\_

Heart \_\_\_\_\_

Lungs \_\_\_\_\_

Anesthetic Proposed:

General  Spinal  Regional  MAC / L. Standby  IV Sedation

No Sedation

Patient Instructed on Anesthesia and Consents to Procedure  Yes  No

Physical Status: 1 2 3 4 5 E

\_\_\_\_\_ am / pm

Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_ Anesthesiologist / Physician Signature

**The following sections do not apply to Pain Management Procedures.**

<b>RECOVERY</b>	BP: _____ P: _____ R: _____ SaO <sub>2</sub> : _____ %
	<input type="checkbox"/> STABLE
<b>Post Anes. Eval.</b>	IN: _____ OUT: _____ TEMP: _____
	Cardio-Pulm. Status: <input type="checkbox"/> Stable <input type="checkbox"/> Unstable
	Level of Consciousness: <input type="checkbox"/> Aware <input type="checkbox"/> Arousable <input type="checkbox"/> Unarousable
	B/P: _____ Pulse: _____ R: _____ Temp: _____ SaO <sub>2</sub> : _____
N/V: None Nausea Vomiting Pain Scale: _____ IV Fluids: _____	
Date: _____ Time: _____ Dr. _____	

All documentation done in Electronic Record System

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Dr. \_\_\_\_\_

\_\_\_\_\_ Anesthesiologist