MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
CONDUCT OF SEDATION AND ANALGESIA, NAVHOSPCAMPENIST 6320.90h	31 JAN 2011

LOCAL FORM TITLE *(Optional)*
PREOPERATIVE ANESTHESIA QUESTIONNAIRE

PLEASE READ: *Modern anesthesia is very safe, but like any medical procedure, there are risks. Major problems, even death or major disability, can occur even in the best situations; however, these are very rare. Before surgery, you will be interviewed by an Anesthesiology Provider and at that time, the risks and benefits of the types of anesthesia will be fully discussed with you and a final choice of anesthetic will be made. Please feel free to ask questions about your anesthesia care. To ensure proper treatment/anesthesia selection, please complete all spaces and answer the questions correctly to the best of your knowledge.*

Name (Last, First, MI):	Age	Height	Weight	Best Contact Phone Number

Any allergies (Medication, foods, latex)?	
If any, type of reaction:	

Please list all medicines, herbal supplements, along with dosage and how often you take them. (additional space on last page)

Medicine, multivitamin, herbal/dietary supplements	Dose	How often taken

PREVIOUS HOSPITALIZATIONS/SURGERIES/ANESTHETICS (additional space on last page)

Date	Hospitalization/Procedure	Anesthetic/General, Spinal, etc.	Anesthesia problems, If Any

THIS SECTION FOR USE BY HOSPITAL STAFF

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

Do you now or have you had any of the following medical conditions? Place a check under Yes or No for each column:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Shortness of Breath	☐	☐	Heart Attack	☐	☐	Stroke	☐	☐	Kidney Problem
☐	☐	Asthma	☐	☐	Chest Pain	☐	☐	Paralysis	☐	☐	Stomach Ulcers
☐	☐	Pneumonia	☐	☐	Irregular Heartbeat	☐	☐	Numbness	☐	☐	Frequent Heartburn
☐	☐	Cold/Flu in last 2 weeks	☐	☐	Heart Murmur	☐	☐	Arthritis	☐	☐	Diabetes
☐	☐	Other Lung Disease	☐	☐	Fainting/Dizziness	☐	☐	Scoliosis	☐	☐	AIDS
☐	☐	Other Cancer	☐	☐	Mental Illness	☐	☐	Liver Problems	☐	☐	Anemia
☐	☐	Chemotherapy	☐	☐	Epilepsy/Seizure	☐	☐	Hepatitis	☐	☐	Other Blood Disease
☐	☐	Radiation Therapy	☐	☐	Nerve Injury	☐	☐	Thyroid Disease	☐	☐	Blood Transfusion
☐	☐	Pacemaker	☐	☐	Frequent Headaches	☐	☐	Hiatal Hernia	☐	☐	Premature Birth
☐	☐	Sleep Apnea	☐	☐	High Cholesterol/Hyperlipidemia	☐	☐	Glaucoma	☐	☐	Hypertension
☐	☐	Chronic Pain	☐	☐	Excessive Snoring	☐	☐	Gout	☐	☐	Fibromyalgia

YES	NO	
☐	☐	Do you wear removable dentures?
☐	☐	Have you ever experienced any post-traumatic/combat related symptoms (PTSD)?
☐	☐	Have you or any close relatives had any unexpected serious reaction to an anesthetic (sleeping medicine for surgery). If yes, please describe:
☐	☐	Do you smoke/use tobacco products? If yes, how many packs/cans/day? Number of years smoking/dipping/chewing? Quit?
☐	☐	Do you now or have you used alcohol? If yes, how much, how often?
☐	☐	In the past 12 months, have you taken steroids (i.e. Prednisone, Hydrocortisone, ACTH)?
☐	☐	In the last 2 weeks, have you taken aspirin, motrin, or similar medications?
☐	☐	Other Medical Problems?
☐	☐	Do you have any barriers that may affect your learning needs? (i.e. Language, Vision or Hearing issues). If yes, please explain:
☐	☐	Do you have someone who will be able to be your escort and assist you with your care for the first 24 hours? If yes, please give name and relationship:
☐	☐	Do you have any special requests? (i.e. Spiritual, Family or Diet Issues). If yes, please explain:

Physical Activity (Circle One): Limited Moderate Very Active

Type of Exercise, if any (example: walking, running, swimming):

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Additional space for medicines you are currently taking and previous surgeries and/or anesthesia procedures:

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Nursing Assessment:

High Risk for PONV:

☐ FEMALE ☐ NON SMOKER ☐ PRIOR HX PONV ☐ MOTION SICKNESS ☐ GYN/ENT

Patient seen by Anesthesiologist/Anesthetist preoperative teaching? ☐ YES ☐ NO

Anesthesia Assessment:

Patient's Signature _____ Time _____ DATE _____

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