PATIENT PRE-ANESTHESIA QUESTIONAIRE

NAME:_____ AGE:_____
CURRENT WEIGHT:_____ HEIGHT:_____
PHONE NUMBER YOU CAN BE REACHED NIGHT BEFORE SURGERY: (____)_____
PHONE NUMBER YOU CAN BE REACHED NIGHT AFTER SURGERY: (____)_____
RELATIONSHIP & NAME OF PERSON ACCOMPANYING YOU: _____

YES NO

_____ _____ 1. Have you ever had any type of anesthesia in the past? Please list surgeries:
_____

_____ _____ 2. Have you or any family members had a problem with anesthesia? Malignant Hyperthermia?
If so which ones? _____

_____ _____ 3. Are you allergic to any medications? Latex allergy? Food allergy?
If so which ones and reaction? _____

_____ _____ 4. Do you use ANY medications, drugs, or eye drops? Diet pills or supplements?
If so please list? _____
Have you had Hepatitis B vaccination? _____

_____ _____ 5. Have you taken any steroid medication in the past six months?

_____ _____ 6. **Female patients**: possibility of pregnancy at time of surgery?
(Yes or No) date of last period: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

_____ _____ 7. High blood pressure?
_____ _____ 8. Chest pain (angina), heart palpitations(arrhythmia)?
_____ _____ 9. Heart attack, heart failure, or heart murmur?
_____ _____ 10. Diabetes?
_____ _____ 11. Thyroid disease or goiter?
_____ _____ 12. Asthma, TB, sleep apnea or other lung problems?
_____ _____ 13. Poor circulation, history of blood clots to lungs or legs?
_____ _____ 14. Seizures, convulsions, black outs, fainting spells, or stroke?
_____ _____ 15. Jaundice, hepatitis, or liver problems?
_____ _____ 16. Hiatal hernia, ulcers, GERD, gastric reflux, gallstones or history of Hepatitis?
_____ _____ 17. Bleeding or clotting problems, anemia?
_____ _____ 18. Kidney problems, recent urinary tract infections or kidney stones?
_____ _____ 19. Recent fever, cold, cough, or sore throat?
_____ _____ 20. Do you smoke? How much?_____
_____ _____ 21. Do you drink alcohol? How much?_____
_____ _____ 22. Do you have any loose teeth, dentures, bridges, capped teeth, or crowns?
_____ _____ 23. Chronic pain, artificial joints?

Signature:_____ Date: _____
Signature of parent or guardian, if patient is a minor _____Date: _____

tenley k lawton m.d.
BOARD CERTIFIED PLASTIC SURGEON

POST OPERATIVE ANESTHESIA INSTRUCTIONS

1. You must have an adult drive you home from the facility. You will not be allowed to drive yourself.
2. Arrangements must have been made for supportive post-operative care by an adult for a minimum of 24 hours post operatively.
3. The effects of anesthesia can persist for 24 hours. You must exercise extreme caution before engaging in any activity that could be harmful to yourself or others.
4. Please avoid the use of alcoholic beverages for the first 24 hours and/or while pain medication is being used.
5. You must follow your Surgeons instructions as indicated for specific surgery instructions. Notify your Surgeon of any unusual changes in your condition.
6. Take only medication that is prescribed by your post operative surgical instruction list

I certify that I have read and had explained to me and fully understand the above instructions.

PATIENT'S SIGNATURE:_____
RESPONSIBLE PARTY:_____
TIME:_____ DATE:_____
WITNESS:_____