PLEASE COMPLETE AND RETURN TO AESTIQUE IN ENVELOPE PROVIDED

PATIENT NAME:		**TYPE OF SURGERY:** **DATE OF SURGERY:** **SURGEON:**	
AGE:	SEX: [ ] MALE [ ] FEMALE	HEIGHT:	WEIGHT:

LIST ALL ALLERGIES	LIST ALL MEDICATIONS, DOSAGES AND FREQUENCY YOU NOW TAKE	LIST ALL OPERATIONS AND DATE

	YES	NO	IF YES, EXPLAIN
HAVE YOU EVER BEEN DIAGNOSED WITH SLEEP APNEA?			
HAVE YOU EVER HAD AN ANESTHETIC? GENERAL / OTHER			
HAVE YOU EVER HAD A PROBLEM WITH ANESTHESIA?			
HAVE YOU EVER BEEN TOLD THERE WAS DIFFICULTY PLACING A BREATHING TUBE?			
HAS ANYONE RELATED TO YOU EVER HAD A PROBLEM WITH ANESTHESIA?			
DO YOU SMOKE? IF YES, HOW MANY PACKS/DAY, HOW LONG?			
DO YOU HAVE A COUGH?			For how long?
DO YOU BRING ANYTHING UP WHEN YOU COUGH?			
HAVE YOU HAD ASTHMA?			When was last attack?
DO YOU CURRENTLY HAVE A COLD?			
HAVE YOU EVER HAD AN ABNORMALITY ON CHEST X-RAY?			When?
HAVE YOU EVER HAD ANY DIFFICULTIES IN BREATHING?			
DO YOU GET SHORT OF BREATH WALKING UP STAIRS?			
ARE YOU EVER SHORT OF BREATH AT NIGHT?			
DO YOU HAVE A HEART MURMUR? IF YES, DO YOU GET ANY MEDICATIONS BEFORE SURGERY?			Name of Medication:
HAVE YOU EVER HAD A HEART ATTACK?			When?
HAVE YOU EVER HAD ANGINA OR CHEST PAIN RELATED TO YOUR HEART?			
HAVE YOU EVER HAD AN ABNORMAL EKG?			When?
DO YOU HAVE A PACEMAKER? IF YES, WHY WAS IT PUT IN?			
HAVE YOU EVER HAD HIGH BLOOD PRESSURE?			
DO YOU TAKE BLOOD THINNERS?			Which one?

**************************ANESTHESIA QUESTIONNAIRE CONTINUES ON REVERSE SIDE*************************

	YES	NO	IF YES, EXPLAIN
HAVE YOU EVER HAD KIDNEY DISEASE?			
HAVE YOU EVER HAD JAUNDICE?			
HAVE YOU EVER HAD HEPATITIS?			
DO YOU HAVE A HIATAL HERNIA, OR GET HEARTBURN?			
DO YOU DRINK ALCOHOL? IF SO, HOW MUCH AND HOW OFTEN?			
DID YOU EVER USE DRUGS?			How long? When?
HAVE YOU EVER HAD A STROKE?			When?
DOES AN ARM OR LEG EVER BECOME NUMB OR WEAK?			
HAVE YOU EVER HAD SEIZURES, EPISODES OF UNCONSCIOUSNESS OR FAINTING?			When?
DO YOU HAVE FREQUENT HEADACHES?			
HAVE YOU EVER HAD EYE OR VISION PROBLEMS?			
DO YOU HAVE DIABETES?			For how long?
HAVE YOU EVER HAD THYROID PROBLEMS?			
DO YOU HAVE BACK PROBLEMS?			What kind?
DO YOU HAVE ARTHRITIS?			Where?
DO YOU HAVE ANY BLEEDING TENDENCIES?			
HAVE YOU EVER BEEN ANEMIC?			When?
HAVE YOU USED ASPIRIN IN THE PAST TWO WEEKS?			How much?
DO YOU HAVE ANY CHIPPED OR LOOSE TEETH, DENTURES, CAPS, BRIDGEWORK, BRACES OR CONTACT LENSES?			Please Specify:
HAVE YOU EVER BEEN CARED FOR BY A PSYCHIATRIST?			When? Why?
FEMALES – DATE OF LAST MENSTRUAL PERIOD			
FEMALES – COULD YOU BE PREGNANT?			
IS THERE ANYTHING ELSE YOU FEEL YOU SHOULD TELL US?			

ACKNOWLEDGEMENT:
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Aestique Ambulatory Surgical Center, Inc. of any changes in my medical status.

Patient Signature: ____ Date: __________________

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