The Methodist Hospital
Anesthesia Patient Health Questionnaire

Patient's Name: _____ DOB: _____ Age: _____

Gender: Male ☐ Female ☐ Height: ____ Feet _____ Inches Weight: _____ pounds

Surgeon: _____ Procedure: _____

Date of Surgery: _____

Contact Numbers: Home _____ Mobile: _____

E-mail Address: _____

1. **List all prescription drugs, over-the-counter medications and herbal supplements that you take:**
   ☐ I do not take medicines or herbal supplements

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. **List all allergies to food, medications and other substances (latex rubber, shellfish, Iodine):**
   ☐ I do not have any known allergies

The Methodist Hospital

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3. **Have you had surgery at The Methodist Hospital System:** **Yes** ☐ **No** ☐

4. **List your previous surgeries:** ☐ **I have never had surgery**

Surgical Procedure	**Year**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. **Any difficulties or complications with previous ANESTHESIA or surgery?** **Yes** ☐ **No** ☐

Severe Nausea or Vomiting	Yes ☐	No ☐
Diffficulty waking up	Yes ☐	No ☐
Awareness while under anesthesia	Yes ☐	No ☐
Difficult intubation (insertion of breathing tube)	Yes ☐	No ☐
Malignant hyperthermia (you or your family)	Yes ☐	No ☐
Blood relative had major complication	Yes ☐	No ☐

Other:_____

6. **Have you ever had HEART, CIRCULATION of BLOOD PRESSURE problems?** **Yes** ☐ **No** ☐

High blood pressure	Yes ☐	No ☐
Angina or chest/arm/jaw pain	Yes ☐	No ☐
High cholesterol	Yes ☐	No ☐
Leg or neck artery blockage	Yes ☐	No ☐
Heart attack	Yes ☐	No ☐
Congestive heart failure	Yes ☐	No ☐
Heart murmur/heart valve problem	Yes ☐	No ☐
Irregular heart beat or palpitations	Yes ☐	No ☐
Defibrillator	Yes ☐	No ☐
Born with a heart problem	Yes ☐	No ☐

Other heart condition _____

The Methodist Hospital

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7. Do you have difficulty climbing two flights of stairs without stopping? **Yes ☐ No ☐**

8. Have you ever had a specialzed heart test or heart procedure? **Yes ☐ No ☐**

Carotid Doppler Study	Yes ☐	No ☐
Holter monitor	Yes ☐	No ☐
Stress test	Yes ☐	No ☐
Heart catheterization	Yes ☐	No ☐
Echocardiogram	Yes ☐	No ☐
Cardiac stent? DATE _____	Yes ☐	No ☐
Heart nuclear scan	Yes ☐	No ☐
Other test or procedure _____		
Have you been told any of these tests were abnormal?	Yes ☐	No ☐

9. Have you ever had breathing problems or a lung condition? **Yes ☐ No ☐**

Asthma	Yes ☐	No ☐
Emphysema or COPD	Yes ☐	No ☐
History of pneumonia	Yes ☐	No ☐
Chronic cough	Yes ☐	No ☐
Sleep apnea	Yes ☐	No ☐
Bronchitis	Yes ☐	No ☐
Recent cold, sore throat (last 2 weeks)	Yes ☐	No ☐
Use oxygen	Yes ☐	No ☐
Shortness of breath	Yes ☐	No ☐
Use CPAP or BiPAP	Yes ☐	No ☐
Other lung or breathing problems?_____		

10. Have you ever had a brain, nerve, muscle or mental health condition? **Yes ☐ No ☐**

Stroke	Yes ☐	No ☐
TIA	Yes ☐	No ☐
Seizures or epilepsy	Yes ☐	No ☐
Paralysis	Yes ☐	No ☐
Numbness or weakness	Yes ☐	No ☐
Multiple sclerosis	Yes ☐	No ☐
Neuropathy	Yes ☐	No ☐
Tremors	Yes ☐	No ☐
Parkinsonism	Yes ☐	No ☐
Loss of bladder or bowel control	Yes ☐	No ☐
Muscle disease	Yes ☐	No ☐
Headache/Migraines	Yes ☐	No ☐
Anxiety	Yes ☐	No ☐
Depression	Yes ☐	No ☐
Other: _____		

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11. Have you ever had any liver or digestive problems? **Yes** ☐ **No** ☐

Ulcer	Yes ☐	No ☐
Hiatal hernia or reflux disease	Yes ☐	No ☐
Gall bladder problems	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐
Yellow jaundice	Yes ☐	No ☐
Cirrhosis	Yes ☐	No ☐
Difficulty in swallowing	Yes ☐	No ☐
Unintentional weight loss	Yes ☐	No ☐

Other: _____

12. Have you ever had a kidney or prostate condition? **Yes** ☐ **No** ☐

Chronic Bladder or kidney infection	Yes ☐	No ☐
Kidney stones	Yes ☐	No ☐
Diminished kidney function/kidney failure	Yes ☐	No ☐
Blood or peritoneal dialysis	Yes ☐	No ☐
Prostate enlargement or cancer	Yes ☐	No ☐

Other: _____

13. Have you ever had blood or clotting disorder? **Yes** ☐ **No** ☐

Anemia	Yes ☐	No ☐
History of blood transfusion	Yes ☐	No ☐
Blood clotting disorder	Yes ☐	No ☐
Sickle cell trait or disease	Yes ☐	No ☐
Transufsion reaction	Yes ☐	No ☐
Brusing without reason	Yes ☐	No ☐
Blood clots in legs or lungs	Yes ☐	No ☐
Use blood thinners	Yes ☐	No ☐

Other: _____

14. Have you had diabetes, thyroid, or endocrine disorder? **Yes** ☐ **No** ☐

Diabetes treated with:	Yes ☐	No ☐
Diet ☐ Pills ☐ Insulin ☐		
Thyroid disease High ☐ Low ☐	Yes ☐	No ☐
Prednisone or steroid use	Yes ☐	No ☐

Other: _____

15. Have you ever had arthritis, spine, joint, or connective tissue problems? **Yes** ☐ **No** ☐

Degenerative arthritis	Yes ☐	No ☐
Osteoporosis	Yes ☐	No ☐
Spine problems:	Yes ☐	No ☐
Neck ☐ Upper back ☐ Lower Back ☐		
Rheumatoid arthritis	Yes ☐	No ☐
TMJ/difficulty opening mouth	Yes ☐	No ☐
Neck stiffness or pain with neck movement	Yes ☐	No ☐
Fibromyalgia/chronic fatigue	Yes ☐	No ☐
Fractures	Yes ☐	No ☐

Other: _____

The Methodist Hospital

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16. For Women

Date of last menstrual period? _____
If pregnant, how many weeks? _____
If pregnant, who is your OB? _____

17. Did you ever, or do you use tobacco, drink alcohol or use illicit drugs? **Yes ☐ No ☐**

Cigarette smoking:
Packs per day ____ Years of smoking ____ If quit, when _____

Cigar or pipe smoking	Yes ☐	No ☐
Alcohol: Drinks per day _____		
Treated for alcoholism in the past?	Yes ☐	No ☐
Marijuana	Yes ☐	No ☐
Cocaine/Crack	Yes ☐	No ☐
Methamphetamines	Yes ☐	No ☐

Other: _____

18. Have you had an organ transplant of any kind? **Yes ☐ No ☐**

Heart	Yes ☐	No ☐
Lung	Yes ☐	No ☐
Kidney	Yes ☐	No ☐
Pancreas	Yes ☐	No ☐

19. Do you have any implants? **Yes ☐ No ☐**

Artificial joints	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐
Defibrillator - AICD	Yes ☐	No ☐
Cardiac Stent	Yes ☐	No ☐
Vascular Stent	Yes ☐	No ☐
Medication Pump	Yes ☐	No ☐
Stimuator - nerve, disphragm, brain….	Yes ☐	No ☐

20. Other medical conditions:

Hearing loss	Yes ☐	No ☐
Vision loss or blindness	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐
Hearing aids	Yes ☐	No ☐
Contact lenses	Yes ☐	No ☐
Dental bridge	Yes ☐	No ☐
Dentures	Yes ☐	No ☐
Loose teeth	Yes ☐	No ☐
Capped teeth/veneers	Yes ☐	No ☐
Dental implants	Yes ☐	No ☐
Tongue or body piercing	Yes ☐	No ☐
Do you have a skin conditon?	Yes ☐	No ☐

21. Have you been hospitalized or been to the ER in the last 12 months: **Yes ☐ No ☐**

22. Have you had an EKG in the last 6 months? **Yes ☐ No ☐**

The Methodist Hospital
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23. Have you had a Chest X-ray in the last 12 months? **Yes ☐ No ☐**

24. Have you ever been hospitalized over a week? **Yes ☐ No ☐**

Why? _____

25. Have you seen someone other than the surgeon in preparation for this surgery? **Yes ☐ No ☐**
(Internal medicine, Pulmonologist or Cardiologist?)

If yes, what is their name and contact information?

Name	Phone	Last Seen
_____	_____	_____
_____	_____	_____
_____	_____	_____

26. List the doctors that you regularly see:

Name	Phone
_____	_____
_____	_____
_____	_____

27. Is there anything that needs to be addressed prior to surgery?

28. How would you rate your health?

- ☐ Healthy
- ☐ Mild disease
- ☐ Severe disease
- ☐ Severe disease that is constant threat to life

I have read and answered above questions truthfully.

Relation to the patient: Self ☐ Parent ☐ Spouse ☐ Other ☐

Signature: _____ Date: _____