Cecille Taylor MD Inc.

Anesthesia Questionnaire

Please complete this form and bring it with you your Pre-Op appointment.

Please fill out this questionnaire completely, answer every question to the best of your ability and understaning.

Your Name: _____ Age: _____ DOB: _____

Gender: _____ Weight: _____ Height: _____

Have you ever had or do you now have:

Heart Trouble	Yes	No	**Paralysis**	Yes	No
Heart Attack	Yes	No	**Blood Transfusion**	Yes	No
Heart Failure	Yes	No	**Blood Clots**	Yes	No
Heart Murmur	Yes	No	**Stroke**	Yes	No
Irregular Heart beat	Yes	No	**Jaundice**	Yes	No
Abnormal EKG	Yes	No	**Hepatitis**	Yes	No
High Blood pressure	Yes	No	**Mononucleosis**	Yes	No
Abnormal Bleeding	Yes	No	**Low Back Pain or "disc"**	Yes	No
Lung Disease	Yes	No	**Arthritis**	Yes	No
Asthma	Yes	No	**HIV Positive or**		
Diabetes	Yes	No	**exposed to AIDS**	Yes	No
Epilepsy or Seizures	Yes	No	**Abnormal chest x-ray**	Yes	No
Glaucoma	Yes	No	**Sickle cell-trait/disease**	Yes	No
Anemia	Yes	No	**Dental or oral problems**	yes	No
Kidney Disease	Yes	No	**Hearing Problems**	Yes	No
Fracture of facial bones	Yes	No	**Do you take Aspirin**	Yes	No
Difficulty opening mouth	Yes	No	**Do you take Coumadin or**		
			Any other blood thinners	Yes	No
			Last Dose _____		

Please list any medications including vitamins, OTC medication, & herbal supplements taken on a regular basis._____

_____

Please list any drug allergies or sensitivities_____

Are you allergic to Latex? YES NO

Please list any chronic illness that you have._____

List previous operations. _____

Were there any complication with anesthesia? YES NO

If yes please explain. _____

Do you have any family history of anesthesia complications? YES NO

If yes please explain. _____

Could you possibly be pregnant? YES NO Do you smoke? YES NO pks/day _____

Do you have a cold or sore throat? YES NO Drink Alcohol? YES NO Amount/wk _____

Do you have any questions about your anesthesia and or surgery? YES NO if yes please state

_____

NAME: _____ DATE: _____