STAFF USE ONLY: Vital Signs: BP _____ Temp _____ Pulse _____ Resp _____ O_2 _____

Signature: _____ Date/Time _____

TMH1753

****PLEASE COMPLETE ALL 6 PAGES**** ****PLEASE COMPLETE ALL 6 PAGES**** ****PLEASE COMPLETE ALL 6 PAGES****

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

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

Surgeon: _____ Chief Complaint: _____

Date of Surgery: _____ Procedure: _____

Preferred Way To Contact You:

☐ **Home Phone:** _____ ☐ **Cell Phone:** _____ ☐ **Work Phone:** _____ ☐ **Other** _____

☐ E-mail Address: _____

***By making a contact selection you are giving us permission to contact you for appointment reminders and other necessary communication**

Name of spouse/significant other (include contact number): _____

1. **List all medicines including over the counter medications, herbals, and other supplements:**

☐ I do not take medicines or herbal supplements

Take Morning of Surgery	Name	Dosage	Frequency
☐			
☐			
☐			
☐			
☐			
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ADHERE PATIENT LABEL WITHIN THIS AREA

HOUSTON Methodist LEADING MEDICINE

FORM # TMH1753 (12/2013)

ANESTHESIA PATIENT HEALTH QUESTIONNAIRE

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

2. **Have you taken any Warfarin, Coumadin, aspirin, plavix, blood thinners, advil, ibuprofen, celebrex, vitamin E, or diet pills during the past 2 weeks?** ☐ **Yes** ☐ **No** **Last dose taken?** _____

3. **List all allergies to food, medications and other substances (latex rubber, shellfish, Iodine, adhesive tape, elastic, latex sensitivity: rubber gloves & latex balloons)**
(Please list what type of reaction do you experience after exposure to the allergen? (ex. Rash)

☐ I do not have any known allergies

_____

_____

_____

_____

_____

4. **Pain within the past 24 hours** ☐ **Yes** ☐ **No**
Location of pain _____ On a scale of 0-10 where would you rate your average pain? _____
What makes pain worse _____
What makes pain better _____
Is the pain chronic, persistent _____
Does the pain come and go _____

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

Implants/Artificial joints		☐ Yes	☐ No
Pacemaker	Last checked _____	☐ Yes	☐ No
Defibrillator - AICD	Last checked _____	☐ Yes	☐ No
Cardiac Stent		☐ Yes	☐ No
Vascular Stent		☐ Yes	☐ No
Medication Pump		☐ Yes	☐ No
Stimulator - nerve, diaphragm, brain....		☐ Yes	☐ No
Bird's Nest/Inferior Vena Cava Filters		☐ Yes	☐ No
Intraocular Lens		☐ Yes	☐ No

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

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

7. **Other medical conditions:**

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

ADHERE PATIENT LABEL WITHIN THIS AREA

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

8. Vaccinations

☐ Flu: within the past year ☐ Pneumonia: within the past 5 years ☐ Tetanus: within the past 10 years

9. Have you ever had Cancer? ☐ Yes ☐ No If yes, when? _____ What type? _____

Were you treated with chemotherapy? ☐ Yes ☐ No If yes when? _____ What type? _____

Have you had radiation therapy? ☐ Yes ☐ No when? _____ Completion: _____

10. Have you ever had HEART, CIRCULATION OR BLOOD PRESSURE problems?	**☐ Yes**	**☐ No**
High blood pressure	☐ Yes	☐ No
Angina/Chest pain	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Leg artery blockage	☐ Yes	☐ No
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 _____

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

12. Have you fallen in the last 12 months? ☐ Yes ☐ No

13. Do you exercise regularly? ☐ Yes ☐ No If so, what type of exercise _____

How many days per week _____ Hours _____ Minutes _____

14. Have you ever had a specialized heart test or heart procedure?	**☐ Yes**	**☐ No**	When Done	Who Ordered
Carotid Doppler Study	☐ Yes	☐ No		
Holter monitor	☐ Yes	☐ No		
Stress test	☐ Yes	☐ No		
Heart cath.	☐ Yes	☐ No		
Echocardiogram	☐ Yes	☐ No		
EKG	☐ Yes	☐ No		
Cardiac stent? ☐ Bare Metal ☐ Drug Eluting	☐ Yes	☐ No		
Heart nuclear scan	☐ Yes	☐ No		

Other test or procedure _____

Why was the cardiac test done? _____

Have you been told any of these tests were abnormal? ☐ Yes ☐ No

15. Have you ever had breathing problems or a lung condition?	**☐ Yes**	**☐ No**
Asthma Last Attack? _____	☐ 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 How many liters? _____	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Use CPAP _____ Setting _____	☐ Yes	☐ No
Use BiPAP	☐ Yes	☐ No

Other lung or breathing problems? _____

ADHERE PATIENT LABEL WITHIN THIS AREA

HOUSTON Methodist LEADING MEDICINE

FORM # TMH1753 (12/2013)

ANESTHESIA PATIENT HEALTH QUESTIONNAIRE

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

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

Stroke	☐ Left ☐ Right	☐ Yes	☐ No
TIA		☐ Yes	☐ No
Seizures or epilepsy	Last Seizure? _____	☐ Yes	☐ No
Paralysis		☐ Yes	☐ No
Numbness or weakness	Where? _____	☐ Yes	☐ No
Multiple sclerosis		☐ Yes	☐ No
Neuropathy		☐ Yes	☐ No
Tremors		☐ Yes	☐ No
Parkinsonism		☐ Yes	☐ No
Loss of bladder control		☐ Yes	☐ No
Loss of bowel control		☐ Yes	☐ No
Muscle disease		☐ Yes	☐ No
Headache/Migraines		☐ Yes	☐ No
Anxiety		☐ Yes	☐ No
Depression		☐ Yes	☐ No
Other mental health condition: List	_____	☐ Yes	☐ No
Motion sickness		☐ Yes	☐ No
Claustrophobia		☐ Yes	☐ No

Other: _____

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

Ulcer	☐ Yes	☐ No
Hiatal hernia	☐ Yes	☐ No
Reflux disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Cirrhosis	☐ Yes	☐ No
Difficulty in swallowing	☐ Yes	☐ No

Other: _____

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

Do you have dialysis? ☐ Blood ☐ Peritoneal	☐ Yes	☐ No
What days of the week _____		
Access _____		
Chronic Bladder or kidney infection	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Diminished kidney function/kidney failure	☐ Yes	☐ No
Prostate enlargement	☐ Yes	☐ No
Prostate Cancer	☐ Yes	☐ No

Other: _____

19. 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
Transfusion reaction	☐ Yes	☐ No
Blood clots in legs or lungs	☐ Yes	☐ No
Use blood thinners	☐ Yes	☐ No

Other: _____

ADHERE PATIENT LABEL WITHIN THIS AREA

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

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

Diabetes treated with: ☐ Diet ☐ Pills ☐ Insulin	☐ Yes	☐ No
Average Blood Sugar? _____ Last Hbg A1C Result _____		
Thyroid disease ☐ High ☐ Low	☐ Yes	☐ No
Prednisone or steroid use	☐ Yes	☐ No

Other: _____

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

Degenerative arthritis	☐ Yes	☐ No
Spine problems: ☐ Neck ☐ Upper Back ☐ Lower Back	☐ Yes	☐ No
Rheumatoid arthritis	☐ Yes	☐ No
TMJ/difficulty opening mouth	☐ Yes	☐ No
Neck stiffness or pain with neck movement	☐ Yes	☐ No
Fractures in the last 12 months	☐ Yes	☐ No
Assistive devices (Cane, Walker, Wheelchair, Etc)	☐ Yes	☐ No

Other: _____

22. For Women

Date of last menstrual period? _____

If pregnant, how many weeks? _____

If pregnant, who is your OB? _____

23. Have you ever, or do you use tobacco, alcohol or illicit drugs? ☐ **Yes** ☐ **No**

Cigarette smoking: Packs per day _____ Years of smoking _____ If quit, when _____		
Cigar or pipe smoking	☐ Yes	☐ No
Quantity per day _____		
Alcohol: Drinks per day _____	☐ Yes	☐ No
Treated for alcoholism in the past?	☐ Yes	☐ No
Marijuana use	☐ Yes	☐ No
Cocaine/Crack	☐ Yes	☐ No
Methamphetamines	☐ Yes	☐ No

Other: _____

24. List <u>all</u> your previous surgeries: ☐ **I have never had surgery**

Surgical Procedure	**Year**

ADHERE PATIENT LABEL WITHIN THIS AREA

HOUSTON Methodist LEADING MEDICINE

FORM # TMH1753 (12/2013)

ANESTHESIA PATIENT HEALTH QUESTIONNAIRE

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

25. **Have you had any surgery at Houston Methodist Hospital:** ☐ Yes ☐ No **Year** _____

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

Severe Nausea or Vomiting	☐ Yes	☐ No
Difficulty 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: _____

			Where?
27. Have you been hospitalized or been to the Emergency Department in the last 12 months:	☐ Yes	☐ No	_____
28. Have you had an EKG in the last 6 months?	☐ Yes	☐ No	_____
29. Have you had a Chest X-ray in the last 12 months?	☐ Yes	☐ No	_____
30. Have you ever been hospitalized over a week?	☐ Yes	☐ No	_____

Why? _____

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

If yes, what is their name and contact information?

Name	Phone	Last Seen

32. **List the doctors and type of doctors (Cardiology, Primary Care, Oncology) that you regularly see:**

Name	Phone	Date of Last Visit

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

_____

_____

_____

34. **Do you need to climb stairs at your home?** ☐ Yes ☐ No

35. **Do you have a religious or other objection against transfusion of blood or blood products if medically necessary?** ☐ Yes ☐ No

36. **Do you have a Medical Power of Attorney/Directives?** ☐ Yes ☐ No

I have read and answered above questions truthfully.

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

Signature: _____

Date: _____ **Time:** _____

ADHERE PATIENT LABEL WITHIN THIS AREA

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ANESTHESIA PATIENT HEALTH QUESTIONNAIRE