North Georgia Eye Surgery Center Anesthesia Pre-Op Questionnaire

(Complete this form and bring to your pre-op appointment)

Patient Name:				Date of Birth:
Sex: M / F	Height:	Weight:	Age:	Phone #:

Have you or anyone realted to you had a high fever or breathing problems with anesthesia? YES NO

Have you had nausea or vomiting with anesthesia? YES NO

Have you ever had a problem with latex products (gloves, tape, band aids, etc.)? YES NO

Have you traveled out of the country in the last 6 months? YES NO

Have you ever had any of the following conditions:

o Stroke	o Paralysis	o Seizures	o Migraines	o TIA	o Dementia
o Anxiety	o Depression	o Bipolar	o Claustrophobia		
o Recent Cold	o Asthma	o Bronchitis	o Emphysema	o Sleep Apnea	o CPAP
o COPD	o Chronic Cough	o Tuberculosis	o Home oxygen	o Shortness of breath	
o Hypertnesion	o Heart Attack	o Chest Pain	o Angina	o CHF	o MVP
o Palpitations	o AFIB	o Pacemaker	o Abnormal EKG	o Cardiac Stents	o Irregular heartbeat
o Hiatal Hernia	o Reflux	o Ulcers			
o Hepatitis	o Cirrhosis	o Jaundice			
o Diabetes	o Insulin	o Oral Meds	o Diet-Controlled	o Hypothyroid	o Hyperthyroid
o Kidney Stones	o Kidney Failure	o Dialysis			
o Arhtritis	o Osteo	oArtifical Joints	o Rheumatoid	o Back/neck Pain	
o Crowns	o Bridges	o Partials	o Dentures	o Loose/broken Teeth	o No Teeth

Has anyone in your immediate family ever had any of the conditions listed above? If so, please explain

Are you taking any type of blood thinner or aspirin?

o Coumadin	o Plavix	o Xarelto	o Aspirin	o Heparin	oEliquis
o Pradexa	o Other				

Have you ever had any type of cancer that included any of the following treatments:

o Excision	o Chemotherapy	o Radiation	o Lumpectomy

Smoking History: # of packs/day	# of years:	Date you quit:	Alcohol: # of drinks/day:

Please list your previous surgeries:

Current Medications (include dosage):

Drug Allergies or Sensitivites (include reaction):