

Northwestern Memorial Hospital

Anesthesiology Preoperative Screening Questionnaire

Today's Date: _____ OR Date: _____
 Name: _____ Age: _____
 Procedure: _____ Surgeon: Michael J. Lee, M.D.
 Patient Phone: Home: _____ Work: _____
 Primary Physician/Location: _____ Phone: _____

The following is a brief set of questions important to your anesthesiologist and your anesthetic management. Circle the appropriate answer and circle or write in the appropriate key words.

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|--|----|-----|--------|
| Do you take any MEDICATIONS prescribed by a physician on a regular basis?
Heart medications/Blood pressure medications
Steroids/Replacement hormones/Anticoagulants (blood thinners)/inhalers
Other _____ | No | Yes | Unsure |
| Have you ever had MEDICATIONS or TREATMENTS prescribed for a major illness?
Include medications prescribed even if you are not currently taking them.
Cancer/Diabetes/Dialysis/Kidney failure
Other _____ | No | Yes | Unsure |
| Have YOU or FAMILY MEMBERS ever had PROBLEMS WITH ANESTHESIA?
Airway problems/difficult intubation/prolonged weakness/
Malignant hyperthermia/abnormal temperature/latex allergy
Other _____ | No | Yes | Unsure |
| Do you have CARDIOVASCULAR / HEART DISEASE?
High blood pressure/Hypertension
Heart attack/Myocardial Infarction
Chest pain/Angina/Myocardial ischemia
Congestive heart failure/Heart valve abnormality
Abnormal heart rhythm/Palpitations
Peripheral vascular disease/Abnormalities with arteries or veins
Heart surgery
Other _____ | No | Yes | Unsure |
| Do you have PULMONARY / LUNG PROBLEMS?
Asthma/Reactive airways disease
COPD/Emphysema/Chronic bronchitis
Tuberculosis
Other _____ | No | Yes | Unsure |
| Do you have NEUROLOGIC / NERVOUS SYSTEM PROBLEMS?
Stroke/ Intracranial bleeding
Neuromuscular disease/Nervous system tumors/Seizures
Other _____ | No | Yes | Unsure |
| Do you have GASTROINTESTINAL / LIVER / STOMACH PROBLEMS?
Hiatal Hernia/Symptomatic reflux/Frequent heartburn/Acid indigestion
Liver disease/Cirrhosis/Hepatitis/Juandice
Other _____ | No | Yes | Unsure |
| Do you have HEMATOLOGIC / BLOOD PROBLEMS?
Hemophilia/Sickle cell anemia/Abnormal bleeding or clotting/AIDS
Other _____ | No | Yes | Unsure |
| Do you SMOKE OR HAVE YOU EVER SMOKED
HEIGHT _____ WEIGHT _____ | No | Yes | Unsure |
| FEMALES of childbearing age: Is there a chance you may be PREGNANT? | No | Yes | Unsure |