RMG IVF/Surgery Center, Inc.

ANESTHESIA PRE-ADMISSION QUESTIONNAIRE

Date Completed _____ Completed by: Patient / Relative / Friend / Staff Member

Surgery Date: _____ Surgeon: _____

Patient Name: _____ Social Security #: _____

Height _____ Weight _____ BMI _____ D.O.B. _____ Age _____

At what telephone number can the patient be reached for Pre-Operative Instructions? **(Day Before)** _____

Can we leave messages on an answering machine? _____ Yes _____ No

Who may we discuss your surgery with other than you? (Name) _____

Where will the patient be staying after surgery? _____ Phone # _____

Who will be staying with the patient after surgery? _____

PLEASE MARK THE FOLLOWING APPROPRIATELY:

YES	NO		EXPLANATION, IF NEEDED
_____	_____	Breathing / Lung Problems	_____
_____	_____	Out of Breath Walking Across Room	_____
_____	_____	Sleep Apnea / Asthma	_____
_____	_____	Seizures / Strokes / Epilepsy	_____
_____	_____	Alzheimers / Dementia / ADD	_____
_____	_____	Bleeding / Bruising Problems	_____
_____	_____	Blood Clots / Free Bleeder	_____
_____	_____	Kidney / Bladder Problems	_____
_____	_____	Dialysis / Urinary Retention	_____
_____	_____	Arthritis / Limitations of Movement	_____
_____	_____	Can't Lay Flat on Back	_____
_____	_____	Heart / High Blood Pressure	_____
_____	_____	Prior Heart Attack / Medications	_____
_____	_____	Liver / Intestinal Problems	_____
_____	_____	Hepatitis / Colostomy	_____
_____	_____	Diabetes / Thyroid Problems	_____
_____	_____	Diabetic Meds / Thyroid Meds	_____
_____	_____	Eye / Ear / Nose / Throat Problems	_____
_____	_____	Snores / Gasps for Breath During Sleep	_____
_____	_____	Difficult Swallowing / TMJ	_____
_____	_____	Do you Smoke	_____
_____	_____	Do you Drink Alcohol	_____

Any other medical problems not listed above? _____

_____

Any surgical operations? (Please give approximate year of surgery, kind of surgery) _____

_____

Has the patient or any member of the patient's immediate family had any problem with anesthesia? _____ No _____ Yes

Explain: _____

_____

_____

Has the patient ever been hospitalized for any reason other than surgery? _____ No _____ Yes (If yes, Explain below, and give when, why and where)

_____

_____

Allergic reactions to any medications? _____ No _____ Yes (If yes, give medication and type of reaction)

_____

Allergic reactions to foods +/or other materials? _____ No _____ Yes (If yes, give food +/or material name and type of reaction (i.e., eggs, latex, iodine, etc.) _____

_____

What prescription medications is the patient taking? *(use additional paper, if needed)*

Name of Medication	Dosage *(amount)*	Frequency *(what time)*	Route *(mouth, injection)*

What diet pills, herbs, vitamins and/or non-prescription medications is the patient taking? _____

_____

What else do you take on a daily basis? (i.e., laxatives, milk of magnesia, etc.)

_____

DO YOU HAVE ANY OF THE FOLLOWING?

YES	NO		YES	NO	
_____	_____	Eyeglasses / Contacts	_____	_____	Dentures / Caps / Bridge
_____	_____	Artifical Limb / Braces	_____	_____	Hearing Aides
_____	_____	Eye Prosthesis	_____	_____	Other _____
_____	_____	Colostomy / Ileostomy	_____	_____	_____

Any additional information you feel will benefit your surgery: _____

_____

Do you have a Medical Power of Attorney? _____ No _____ Yes

Do you have a Living Will? _____ No _____ Yes (If yes, please bring a copy with you for your file. RMG IVF/Surgery Center does not honor living wills, but in the unlikely event an emergency does arise, it will be honored at the transferring hospital.)

Is a language or method other than English your primary means of communication? _____ No _____ Yes *(Explain below)*

I give permission for RMG IVF/Surgery Center to obtain my medical records and test results from my other physicians and places of care that are needed for preparing for my surgery. If you have any concerns about releasing my records/information, please call me.

Authorized Signature _____ Witness _____

❑ Patient ❑ Parent ❑ Legal Guardian ❑ Power of Attorney

It is preferred that the legal / authorizing adult be present the day of surgery. If permits are not presigned and the authorizing / legal adult is not present, the surgery will be cancelled.

<u>DO NOT</u> bring any valuables with you. <u>DO NOT</u> bring more than $5.00 other than your deductible or co-pay.

<u>DO</u> bring a list of <u>ALL</u> your medications, including strength and dosage with you.

Anesthesia Review _____ Date _____