

Pre-Anesthesia Questionnaire

In anticipation of your upcoming surgery, please complete this form before your pre-admission testing visit or phone screening. This information will help our staff determine the best care for you or your family member during your upcoming surgery.

Patient's name: _____

Date of birth: _____ Age _____ Weight _____ Height _____

Date of surgery _____ Name of surgeon _____

Procedure _____ Medical doctor _____

Do you have Advance Directives? Yes No MOLST? Yes No

Agent's name _____ Their phone number _____

Do you have any dietary restrictions? Y N If so, please explain _____

Do you have difficulty swallowing? Y N Do you have difficulty chewing? Y N

Date of last tetanus shot? _____ Flu shot? _____ Pneumonia vaccine? _____

Have you ever been a victim of abuse or neglect? Y N

Do you have a pacemaker / defibrillator? Y N
If yes, please bring us a copy of your information card.

Have you or anyone in your family had a reaction to anesthesia? Y N
If yes, please explain _____

Are you allergic to any foods or medications? Y N
If yes, to what, and what is the reaction? _____

Are you allergic to latex, seafood, X ray dye or iodine? Y N
If yes, to what, and what is the reaction? _____

Do you drink alcohol? Y N *If yes, number of drinks per day _____ or per week _____*

Do you smoke? Y N *If yes, number of packs per day _____ or per week _____*

Please list any other information you feel would help make your stay with us *better*?

_____ *please complete the next page*

Have you ever had or do you presently have any of the following (check all that apply)?

<input type="checkbox"/>	A recent cold	<input type="checkbox"/>	GERD / Acid reflux
<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Other GI disease
<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Chemotherapy / Radiation
<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	Blood clot / Pulmonary embolism
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	Antibiotic resistant organisms	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	MRSA or VRE	<input type="checkbox"/>	Emphysema / COPD
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Back injury or pain
<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Stroke / TIA	<input type="checkbox"/>	Any type of seizure
<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	Last episode: _____
<input type="checkbox"/>	Anxiety attacks	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Heart attacks	<input type="checkbox"/>	Use of prescribed insulin
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Use of prescribed inhalers
<input type="checkbox"/>	Rapid heartbeats	<input type="checkbox"/>	Use of prescribed steroids
<input type="checkbox"/>	Heart murmurs	<input type="checkbox"/>	Use of recreational/illicit drugs
<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	Use of marijuana
<input type="checkbox"/>	Cardiac catheterization	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Cardiac stent placement	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	Stress / Echo cardiogram	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Who is your cardiologist?	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	_____	<input type="checkbox"/>	Hiatal hernia
<input type="checkbox"/>	When was your last cardiology visit?	<input type="checkbox"/>	Depression
<input type="checkbox"/>	_____	<input type="checkbox"/>	Bipolar disorder
<input type="checkbox"/>	_____	<input type="checkbox"/>	Schizophrenia

Please list past surgeries and approximate dates

Please list all medications currently being taken

Drug	Dosage	When taken last

you may use the back of this form if necessary

Appointing a Healthcare Proxy in New York State

New York State Health Proxy Law allows you to appoint someone you trust – for example, a family member or close friend – to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent’s decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow.

To appoint a proxy, fill out the Health Care Proxy document on the following page, sign it, date it, and have two witnesses sign and date it. *Your agent may not be a witness to the document.*

Your agent can be any adult who is over the age of 18 or a minor who has married or is the parent of a child.

If you should ever change your mind about the wishes stated in your proxy or about the person you have designated to be your agent, you can revoke your proxy at any time by advising your health care provider(s) or your hospital verbally or in writing.

You can name an alternative agent when you sign your proxy, so if your agent cannot be contacted, the alternative agent can make decisions.

Talk to the person who is named as your agent, and give the agent a *copy* of the form. Give *copies* to your doctors and to any hospital or nursing home in which you are a patient. *Be prepared to show them the original document.* Tell family and those closest to you about the proxy and give them *copies*. Retain the original and a list of all parties to whom you have given copies so you can inform them all if you change who you list as agent(s) or revoke the proxy.

New York State Health Care Proxy Form

1. I, (print first and last name) _____ hereby appoint

(name) _____ (home address) _____ (phone) _____

as my health care agent to make any and all health care related care decisions for me, except to the extent that I have stated otherwise. (Your agent can be any adult who is over the age of 18 or a minor who has married or is the parent of a child.) This proxy shall take effect when and if I become unable to make my own health care decisions.

2. Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. *Attach additional page(s) if necessary.*

Unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration.

3. Name of alternative agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent:

(name) _____ (home address) _____ (phone) _____

4. Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated here. (This proxy shall expire on this specific date or upon the following condition)

5. Signature: _____ Date: _____

Home Address: _____

Statement by Witnesses

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1: _____ Date: _____

Home Address: _____

Witness 2: _____ Date: _____

Home Address: _____