# Anesthesia Questionnaire

Date: Month_____DD_____, 20YY_____

Name: _____ Height: _____ cm

Date of Birth: Month_____DD_____, 20YY_____ Weight: _____ kg

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|---|---|---|---|---|
| 1. At this hospital, blood transfusions are performed if medically indicated. Do you consent to blood transfusion if necessary? | | | Yes | No |
| 2. Can you climb one flight of stairs without having to take a rest? | | | Yes | No |
| 3. Do you exercise regularly? | Yes | No | Type of exercise: | |

| | | | |
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| 4. Have you ever had surgery? | | Yes | No |
| When? (e.g. what year, years ago, or your age at the time) | Diagnosis / Type of Surgery | Any difficulties or complications with anesthesia? | |
| | | Yes / No | |
| | | Yes / No | |
| | | Yes / No | |
| | | Yes / No | |
| 5. Do you have any blood relatives who have experienced difficulties or complications during anesthesia? (high fever, cardiac arrest, etc.) | | Yes | No |
| 6. Do you easily develop motion sickness? | | Yes | No |

| | | |
|---|---|---|
| 7. Have you ever smoked? | Yes | No |
| ① If "Yes," smoked ____cigarettes a day for____years; quit around Month_____YYYY_____ | | |
| ② If you are "presently smoking," would you like to see someone at the smoking cessation clinic? | Yes | No |
| 8. Do you drink alcohol? | Yes | No |
| ① If "Yes," → (How often) ____daily, _____weekly, _____occasionally____ (What kind of alcohol) _____ (Amount per day)_____ | | |

| | | |
|---|---|---|
| 9. Have you ever had an allergic reaction like a rash or itchiness with any of the following foods or other substances? | | |
| ① Food: avocado, kiwi, banana, chestnuts, other: _____ | Yes | No |
| ② Medications: Name of medicine: _____ | Yes | No |
| ③ Disinfectants: alcohol, isodine (povidone iodine), other:_____ | Yes | No |
| ④ Rubber products: latex gloves, condoms, rubber bands, other:_____ | Yes | No |
| ⑤ Do you have any of these conditions: → Rhinitis / hay fever / allergic conjunctivitis | | |

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| 10. | Have you had any of the following? (Other than what you are having surgery for)<br>If "Yes," please circle (○) or write the diagnosis (name of disease) or other details. | | |
| ① | Neurologic / Psychiatric diseases: stroke, Parkinson's, depression, schizophrenia, other: _____ | Yes | No |
| ② | Have you ever experienced convulsions / loss of consciousness? _____ | Yes | No |
| ③ | Eye diseases: cataracts, glaucoma, artificial eye, other: _____ | Yes | No |
| ④ | Heart / Cardiovascular diseases: hypertension, myocardial infarction, angina, valvular disease, arrhythmia, pacemaker, other: _____ | Yes | No |
| ⑤ | Lung / Respiratory diseases: asthma, sleep apnea syndrome, emphysema, tuberculosis, interstitial pneumonia, other: _____ | Yes | No |
| ⑥ | In case of "asthma," most recent attack: Month DD , YYYY ; Medication: Routine / Attacks only / None | | |
| ⑦ | Have you ever been told that you snore while sleeping? | Yes | No |
| ⑧ | Endocrine diseases: diabetes, thyroid disorders, diabetes insipidus, other: _____ | Yes | No |
| ⑨ | Gastrointestinal diseases: stomach / duodenal ulcer, liver disease, reflux, other: _____ | Yes | No |
| ⑩ | Blood diseases: leukemia, anemia, other: _____ | Yes | No |
| ⑪ | Muscle, joint, and skin diseases: myasthenia gravis, muscular dystrophy, rheumatoid arthritis, cervical spondylitis, atopic dermatitis, other: _____ | Yes | No |
| ⑫ | Urologic diseases: benign prostatic hyperplasia, renal failure, other: _____ | Yes | No |
| ⑬ | Other disease(s) not mentioned above: _____ | | |

| | | | |
|---|---|---|---|
| 11. | Do you take any medications prescribed / provided other than from this hospital? | Yes | No |
| | If "Yes," please provide the names of the other medicines you are prescribed and/or taking:<br>➢ If you do not know the names of the medicines, tell us why you take them, e.g. "2 different medicines for high blood pressure."<br>➢ If you are on any medications, you MUST bring something we can identify them with (a written list like your Medication Notebook, the prescriptions, or the actual medications) when you come for your anesthesia consultation.<br>_____<br>_____<br>_____ | | |
| 12. | If you take any vitamins/supplements, over-the-counter medicines, or health foods, please write them here:<br>_____<br>_____ | | |

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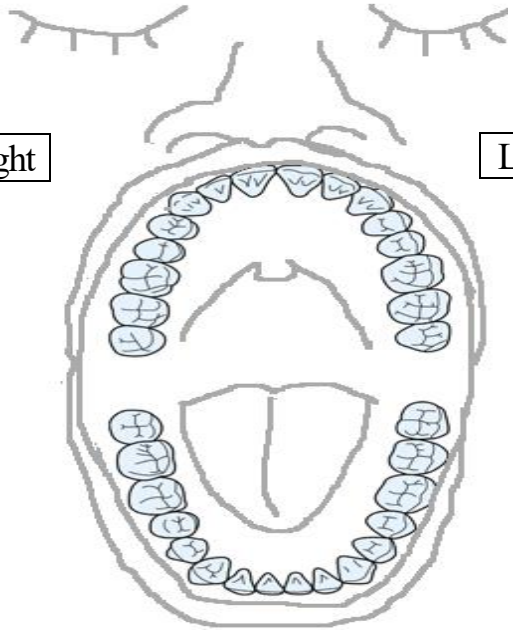
| | | | |
|---|---|---|---|
| 13. | Questions about your oral care, teeth and dental treatments | | |
| ① | Do you have any dental issues? | Yes | No |
| ② | If "Yes", please circle (○) related symptoms below or describe what they are:<br>toothache / pain of the gums / bleeding from the gums / loose teeth / dentures do not fit properly / Other:_____ | | |
| ③ | Do you see your dentist regularly? | Yes | No |
| ④ | When did you last visit the dentist? Around Month_____YYYY_____ | | |
| ⑤ | Do you have any teeth which are presently undergoing treatment? | Yes | No |
| ⑥ | When is your next dentist appointment? Around Month_____YYYY_____ | | |

Let us know the condition of your teeth using the diagram here:




- ❖ Mark sites where you have no teeth with an "X"
- ❖ Mark details such as those below:
  "Loose tooth"
  "Dentures"
  "Ceramic"
  "False tooth"
  "Implant," etc.

**If you have not been to the dentist within the past 6 months, or if you have loose or bad teeth, we recommend you see a dentist before your anesthesia consultation.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 14. | For women: | | | | | | |
| ① | Are you pregnant? | Yes | No | ② | Are you presently breastfeeding? | Yes | No |

15. If you have any questions about the anesthesia or surgery, or if you have any concerns you wish to discuss, please write them here:_____

Thank you for your cooperation.



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