

**BON SECOURS COMMUNITY HOSPITAL
MATERNITY PRE-ANESTHESIA QUESTIONNAIRE**

EXPECTED DATE OF DELIVERY: _____

OBSTETRICIAN: _____, **M.D.**

NAME: _____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____

TELEPHONE #: **DAY:** _____ **EVENING:** _____

To our Patients: Please help us plan the very best anesthetic for you by answering the following questions:

Have you had, or still have:	Yes	No	For MD Only	Have you had, or still have:	Yes	No	For MD Only
Recent cold				Back pain/injury			
Bronchitis/cough				Slipped disc/sciatica			
Asthma				Convulsions			
Hayfever				Epilepsy			
Tuberculosis				Gallbladder trouble			
Emphysema				Infectious mono			
Pneumonia				Stroke			
Difficulty breathing				Polio, paralysis			
Other lung trouble				Meningitis			
Do you smoke				Thyroid trouble			
Did you smoke				Diabetes			
Rheumatic fever				Low blood sugar			
Heart murmur				Kidney trouble			
High blood pressure				Are you on dialysis			
Low blood pressure				Arthritis			
Chest pain/angina				Jaundice, hepatitis, liver trouble			
Heart attack(s)				Do you drink alcohol			
Palpitations: fast or irregular heart beat				Have you had any blood transfusions			
Bleeding tendency							
Bruise easily							

Have you ever received anesthesia for a previous birth? [] Yes [] No
 Do you have any areas of concern regarding anesthesia? [] Yes [] No
 Would you like to be contacted by a member of the anesthesia department? [] Yes [] No
 What operations have you had: _____
 Have you or your family had an unusual reaction to anesthesia? [] Yes [] No
 If YES, explain: _____
 Do you have any loose or capped teeth? [] Yes [] No
 Do you have any allergies? [] Yes [] No If YES, please list: _____
 Are taking any medications: [] Yes [] No If YES, please list: _____
 Who is your internist or family doctor? _____
 Date of last visit: _____
 Is there anything else that you would like to tell us? _____

Date: _____ Patient Signature: _____
 Date: _____ Nurse Reviewer: _____
 Date: _____ Evaluating Anesthesiologist: _____

