ANESTHESIA PRE-ADMIT SCREENING SERVICE (APASS)

PRE-OPERATIVE QUESTIONNAIRE

Date: ________________________________

<table>
<thead>
<tr>
<th>PATIENT’S LEGAL NAME:</th>
<th>________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICKNAME:</td>
<td>________________________________</td>
</tr>
<tr>
<td>SURGEON:</td>
<td>________________________________</td>
</tr>
<tr>
<td>DOB:</td>
<td>________________________________</td>
</tr>
<tr>
<td>DATE OF SURGERY:</td>
<td>________________________________</td>
</tr>
<tr>
<td>PROCEDURE:</td>
<td>________________________________</td>
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</tbody>
</table>

Who may we call regarding questions about the patient’s medical history?
Person to call: _____________________ Relationship to patient: ______________________
Contact phone #s (including area code): ____________________________________________

If the patient is in DHR custody, please provide DHR contact information.
DHR County: __________________________ Caseworker’s Name: __________________________
Caseworker’s Contact phone #s (including area code): ________________________________

FAMILY HISTORY
(Patient’s blood relatives)

Is there a FAMILY HISTORY of:

1. serious complications or unexpected death related to anesthesia? NO YES
2. dangerously high fevers associated with anesthesia (Malignant Hyperthermia)? NO YES
3. sensitivity to anesthesia medications (Pseudocholinesterase Deficiency)? NO YES
4. muscle disease (Muscular Dystrophy, etc.)? NO YES
5. bleeding disorders (Hemophilia, Von Willebrand Disease, etc)? NO YES
6. blood disorders (Sickle Cell Trait, Sickle Cell Anemia, Thalassemia, etc)? NO YES

If YES for questions #1-6, please explain: ____________________________________________

PATIENT RECENT ILLNESS

Has the PATIENT:

1. had a cold or upper respiratory tract infection in the last 14 days? NO YES
2. had a stomach virus in the last 7 days? NO YES
3. had bronchitis/bronchiolitis, croup, pneumonia or flu in the last 6 weeks? NO YES
4. been treated with steroids (prednisone, prednisolone, orapred) in the last 6 weeks? NO YES
5. been seen in an Emergency Room in the last 2 months? NO YES
6. been admitted to the hospital in the last 3 months? NO YES

If YES to questions #1-6, please explain: ____________________________________________
**PATIENT HISTORY**

**ALLERGIES**

**MEDICATIONS**

Does the patient have problems opening the mouth, moving the neck or tilting the head?  
NO  YES

If YES, explain mouth, neck or head problems: __________________________________________

Has the patient ever had surgery or anesthesia?  
NO  YES

**SURGERIES** (please list)  
If the patient has had previous surgery, did they have problems with Anesthesia?  
NO  YES

If YES, explain anesthesia problems: __________________________________________________

Please check all that apply to the **PATIENT MEDICAL HISTORY**.

<table>
<thead>
<tr>
<th>Birth hospital: ________________________</th>
<th>Birth weight: ________________________</th>
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</thead>
<tbody>
<tr>
<td>How long did the patient stay in the hospital at birth?______________________________</td>
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</tr>
<tr>
<td>☐ Full term (&gt; 37 weeks)</td>
<td>☐ Premature (&lt;37 weeks)</td>
</tr>
<tr>
<td>☐ Vent at birth x_________</td>
<td>☐ Oxygen at birth x_________</td>
</tr>
<tr>
<td>☐ Birth complications: __________________________________________________________</td>
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</tbody>
</table>

☐ Acid reflux ☐ Down Syndrome ☐ Paralysis  
☐ Airway condition ☐ Feeding tube ☐ Seizures  
☐ Asthma ☐ Heart condition ☐ Sickle cell anemia  
☐ Autism ☐ Heart murmur ☐ Sickle cell trait  
☐ Bleeding disorder ☐ High blood pressure ☐ Sleep apnea  
☐ Blood disorder ☐ Home oxygen ☐ Thyroid condition  
☐ Bronchopulmonary dysplasia (BPD) ☐ Home vent ☐ Trach  
☐ Cancer ☐ Immune condition ☐ Transplant  
☐ Cerebral palsy (CP) ☐ Kidney condition ☐ Tuberculosis (TB)  
☐ Cochlear implant ☐ Liver condition ☐ Vagal nerve stimulator (VNS)  
☐ CPAP/BiPAP ☐ MRSA ☐ Wheezing  
☐ Diabetes ☐ Muscle disease ☐ OTHER: ____________________________

Primary Care Provider (PCP): ________________________  
PCP #: ________________________  
PCP City: ________________________

Specialty Care Providers: ________________________