P.A.T Questionnaire

Provide the safest care possible, these questions are required by our Anesthesia Department. Please tak a moment and complete as accurately as you can. Thank you for letting us care of you.

Patient Name	Date of Birth	Age	Height	Weight

Proposed Surgery	Medication Allergies (Please list)	☐ NO Known Allergies	Egg Allergy
			NO YES

List ALL Medications/Supplements/ Herbals/Over the Counter Pills you take: ______________________________

	NO	YES	
Do you drink Alcohol?			How much? ______________
Do you smoke?			How many PPD? ______________
Do you use recreational Drugs?			Please List: ______________

List All Surgeries you have had: ______________________________

HAVE YOU EVER HAD?	NO	YES	
Chest Pain / Angina			How Often ______________
Heart Attack			When (Date) ______________
Heart Failure			
A. Fib / Pacemaker			
Arrythmias / Defibrillator			
Stents			
Leg Pain / Clotting			
Heart Surgery			Do you use O2 or CPAP at home? NO YES
High Blood Pressure			
Asthma			Can you climb 1 flight of Stairs? NO YES
Emphysema / COPD			How far can you walk? ________Feet ________ Blocks
Recent Pneumonia			
Liver Disese			
Hepatitis			
Kidney Disease.(Not Stones)			
Dialysis			When (Date) ______________
Renal Failure			
Diabetes			Do you take insulin? NO YES
Low Blood Sugar			What are your usual Blood Sugars? ______________
Seizure / Convulsions			
Nerve Damage			
Paralysis			
Stroke			When (Date) ______________
Anemia			
Steriod use more than 6 mon.?			
Do you have an infection now?			Where ______________
Serious Staph / MRSA Infection?			When (Date) ______________

	NO.	YES
Have you ever had any problems with Anesthesia?		
Have you ever been told you are difficult to intubate?		
Have any family members had other problems with anesthesia?		
Have you had a high fever with anesthesia? (Malignant Hyperthermia)		
Has any close family member had high fever with Anesthesia?(Malignant Hyperthermia)		

Signature of person completing form	Date