



ORLANDO HEALTH

1414 Kuhl Ave. • Orlando, FL 32806

OBSTETRICAL ANESTHESIA QUESTIONNAIRE

LINE UP PATIENT I.D. LABEL HERE

1. Please list any major illnesses you have had in your life.

2. Please list any medication that you take and their doses, including herbal medication.

CHECK THE FOLLOWING QUESTIONS YES OR NO **YES** **NO**

3. Have you taken prednisone, steroids, or ACTH? If yes, when? _____

4. Are you allergic to any medicines? If yes, what kind? _____
If yes, what happens? _____

5. Have you ever had high or low blood pressure? If yes, which? _____

6. Have you ever had trouble with your heart? _____

7. Have you ever had a heart attack? If yes, when? _____

8. Do you have chest pains? If yes, how often? _____

9. Do you have any troubles with your breathing or lungs? _____
(check all that apply) Asthma Wheezing Emphysema Cough anything up

10. Do you smoke? How much? _____ How long? _____

11. Do you have any problems with your breathing while lying flat? _____

12. Have you ever had a stroke? If yes, when? _____

13. Have you ever had dizziness, fainting spells, seizures or epilepsy? _____

14. Do you have any part of your body that is numb or weak? _____

15. Have you ever had any problems with your liver or kidneys? _____

16. Have you ever had hepatitis or yellow jaundice? If yes, when? _____

17. Do you have problems with swallowing, heartburn, indigestion, hiatal hernia or vomiting? _____

18. Do you have diabetes? How long? _____

19. Do you have arthritis? If yes, where? _____

20. Have you ever had problems with bleeding or easy bruising? _____

21. Have you ever had a transfusion? If yes, when? _____

22. Do you wear contact lenses? _____

23. Do you have (check all that apply) dentures caps bridges loose teeth chipped teeth

24. Have you ever had any operations? If yes, please list type and date. _____

25. Have you ever had any problems with a general anesthetic? If yes, what? _____

26. Have you ever had any problems with a spinal or epidural anesthetic? _____

27. Have any relatives had any problems with anesthetics? What? _____

28. Do you drink alcohol? Number of alcoholic drinks/beer per day? _____ Week? _____

29. Do you have any problems with your back? _____

30. Do you have a birthing plan? _____

Signature: _____ Date: _____ Time: _____