Demographics Form **Today's date** _____

Please fax completed form to Admitting Nurse/Pre-Reg at 916-423-6002 (for Main OR cases) or 916-688-0508 (for Outpatient Surgery cases).

Surgeon _____ Surgery date _____ Diagnosis _____ Date of injury _____

PATIENT INFORMATION

Last name _____ Title _____ First name _____ Middle initial _____
Social security no. _____ Sex _____ Date of birth _____ Age _____ Birth state _____
Marital status _____ Religion _____ Ethnicity _____ Primary language _____
Interpreter needed _____ Mailing address _____
City _____ State ____ Zip code _____ Country of residence _____
Street address (if different than mailing address) _____
City _____ State ____ Zip code _____ Country _____
Home telephone no. (_____)_____ Cell phone no. (_____)_____
Employment status/Retirement date _____ Employer _____
Occupation _____ Address _____
City _____ State ____ Zip code _____ Work phone (_____)_____
Primary Care Physician _____
Other physician(s) _____

SPOUSE/GUARDIAN INFORMATION

Last name _____ First name _____ Middle initial _____
Social security no. _____ Date of birth _____ Same address as patient _____
If "No," what is mailing address _____
City _____ State ____ Zip code _____ Phone (_____)_____
Employment status/Retirement date _____ Employer _____
Occupation _____ Address _____
City _____ State ____ Zip code _____ Work phone (_____)_____

EMERGENCY CONTACT INFORMATION

Last name _____ First name _____ Middle initial _____
Relationship to patient _____ Date of birth _____ Address _____
City _____ State _____ Zip code _____
Home telephone no. (_____)_____ Cell phone no. (_____)_____

INSURANCE INFORMATION – PRIMARY

Plan name _____ Address _____
City _____ State ____ Zip code _____ Authorization no. _____
Policy no. _____ Group no. _____ Group name _____
Subscriber: Patient/Spouse/Guardian/Other _____ No. of insurance-approved days _____
If "Other," what is Last name _____ First Name _____ Middle initial _____
Date of birth _____ Sex _____ Employment status/Retirement date _____
Employer _____ Occupation _____ Address _____
City _____ State _____ Zip code _____ Phone (_____)_____

INSURANCE INFORMATION – SECONDARY

Plan name _____ Address _____
City _____ State ____ Zip code _____ Authorization no. _____
Policy no. _____ Group no. _____ Group name _____
Subscriber: Patient/Spouse/Guardian/Other _____ No. of insurance-approved days _____
If "Other," what is Last name _____ First Name _____ Middle initial _____
Date of birth _____ Sex _____ Employment status/Retirement date _____
Employer _____ Occupation _____ Address _____
City _____ State _____ Zip code _____ Phone (_____)_____

CYRA phone interpreter no. (_____)_____ Additional notes _____

Methodist Hospital of Sacramento
A Dignity Health Member

Anesthetic Questionnaire

Patient's Name: _____ Date: _____

Date of Surgery: _____ Surgeon: _____ Family M.D.: _____ Cardiologist: _____

Age: _____ Height: _____ Weight: _____ Sex: ☐ M ☐ F Have you been a patient here before? _____ yr. _____

DRUG ALLERGIES: _____ Latex Allergy? ☐ Yes ☐ No

Please List Any Medication, Injection, or Pills Taken on a Regular Basis:

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

LIST ADDITIONAL MEDICATIONS ON SEPARATE PAPER

Have you had Anesthesia before?
If yes, which: GEN / LOC / SPINAL _____

Have you or any blood relative had a problem with anesthesia? ☐ Yes ☐ No

What? _____

Have you had post-op nausea? ☐ Yes ☐ No

☐ Mild ☐ Moderate ☐ Severe

List Previous Operations:

1 _____ (_____ yr.) 2 _____ (_____ yr.) 3 _____ (_____ yr.) 4 _____ (_____ yr.) 5 _____ (_____ yr.)

DO YOU HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?
PLEASE CHECK APPROPRIATE COLUMN AND CIRCLE CHOICE.

YES	NO	
		HEART PROBLEMS - IF YES, WHAT? _____
		HIGH OR LOW BLOOD PRESSURE, IF YES CIRCLE ONE.
		STROKE? WHEN? _____
		LUNG PROBLEMS OR PNEUMONIA OR TUBERCULOSIS?
		ASTHMA OR SLEEP APNEA?
		EPILEPSY, SEIZURES OR MULTIPLE SCLEROSIS?
		BLEEDING PROBLEMS?
		BLOOD TRANSFUSIONS?
		KIDNEY OR URINARY PROBLEMS?
		NERVOUS OR EMOTIONAL PROBLEMS?
		ARTHRITIS?
		LIVER PROBLEMS - IF YES, WHAT IS PROBLEM? _____
		HAVE YOU EVER HAD HEPATITIS OR HIV? IF YES, WHAT TYPE? _____
		CANCER - IF YES, WHAT TYPE? _____
		INDIGESTION, HIATAL HERNIA OR GASTRIC REFLUX?
		DIABETES, RAYNAUD'S OR BERGER'S DISEASE?
		MYASTHENIA GRAVIS OR GUILLAIN-BARRÉ DISEASE
		HAVE YOU USED ANY RECREATIONAL DRUGS IN THE PAST MONTH?
		IS THERE ANY POSSIBILITY YOU COULD BE PREGNANT?
		HAVE YOU TAKEN ANY STEROID PREPARATIONS IN THE PAST YEAR? (PRED. CORTISONE, ETC.)
		HAVE YOU TAKEN ASPIRIN, PLAVIX OR COUMADIN IN THE LAST 5 DAYS?
		WERE YOU SEEN PREOPERATIVELY BY A MEDICAL DOCTOR FOR CLEARANCE? IF YES, DR. _____

YES	NO	SICKLE CELL
		HAVE YOU BEEN TESTED FOR SICKLE CELL TRAIT?
		DOES ANYONE IN YOUR FAMILY HAVE THE SICKLE CELL TRAIT?
		DO YOU HAVE ANEMIA DUE TO SICKLE CELL DISEASE?

Do You Smoke Now? ☐ Yes ☐ No How Much Each Day? _____ packs for _____ yrs.

Have You Ever Smoked? ☐ Yes ☐ No How much: _____ packs for _____ yrs. When quit _____

How Much Alcohol Do You Drink? ☐ None ☐ Seldom ☐ Occasionally ☐ Daily

Patient Signature: _____ Date: _____

ANSWER DAY OF SURGERY

When Did You Last Have Something to Eat or Drink? _____

Do You Have Loose Teeth, Bridgework, Dentures or Caps? ☐ Yes ☐ No ☐ U ☐ L ☐ Partial

Do You Have Any Questions? _____