Patient Label

Patient Health History/Pre-Anesthesia Evaluation

Date: ________ Time: ________ Primary Language ☐ English ☐ Spanish Other: ________

Patient Name: ________ Surgeon: ________

Surgery: ________

Your primary doctor: ________ Office # (____) ________

Height: ________ Weight: ________ Age: ________

INSTRUCTIONS TO PATIENT: This questionnaire will help your Anesthesiologist select the proper anesthetic for you. Please check the appropriate boxes and fill-in needed information.

Your Medical History

- ☐ No ☐ Yes Have you ever had a transfusion of blood or blood products? If yes, when? ________
- ☐ No ☐ Yes If medically necessary, would you accept a blood transfusion?
- ☐ No ☐ Yes For women, currently pregnant? If yes, # of weeks ____ If no, last menstrual period: ________
- ☐ No ☐ Yes Do you now, or did you ever smoke? How much? ____ When did you quit? ________
- ☐ No ☐ Yes Do you drink alcohol? Type? ______ How much/often ______
- ☐ No ☐ Yes Have you ever had alcohol withdrawal?
- ☐ No ☐ Yes Do you use any illicit or recreational drugs? If yes, describe: ________
- ☐ No ☐ Yes Is there any possibility that you have any communicable diseases at this time? ________
- ☐ No ☐ Yes Have you traveled outside if the U.S. in the past two years? ________
- ☐ No ☐ Yes Has anyone in your family had a tendency to bleed excessively? If yes, explain: ________
- ☐ No ☐ Yes Has anyone in your family had unusual reactions or problems with anesthesia? If yes, explain: ________
- ☐ No ☐ Yes Has anyone in your family had unexplained fevers during or following surgery? ________

Please check if you ever had the following and enter the date

- ☐ Heart disease ________
- ☐ Heart murmur ________
- ☐ Prolapsed mitral valve ________
- ☐ Heart attack ________
- ☐ Palpitations (Irregular heart beat) ________
- ☐ Chest pain ________
- ☐ Recent cardiac studies (stress test, echo, wall motion) ________
- ☐ High blood pressure ________
- ☐ Wake up at night with shortness of breath ________
- ☐ Kidney disease ________
- ☐ Thyroid disease ________
- ☐ Diabetes ________
- ☐ Asthma or frequent wheezing ________
- ☐ Emphysema ________
- ☐ Bronchitis ________
- ☐ Recent pulmonary functions tests ________
- ☐ Sleep Apnea ________
- ☐ Tuberculosis ________
- ☐ Stroke ________
- ☐ Frequent headaches ________
- ☐ Fainting spells ________
- ☐ Epilepsy/Seizures ________
- ☐ Chicken Pox/Shingles ________
- ☐ Neurological disease ________
- ☐ Back pain/problems ________
- ☐ Hepatitis (Yellow Jaundice) (A, B, or C) ________
- ☐ Blood clots ________
- ☐ Easy bruising or bleeding ________
- ☐ Sickle Cell disease ________
- ☐ Cancer ________
- ☐ AIDS/HIV ________
- ☐ Serious illness during pregnancy ________
- ☐ Glaucoma ________

Comments: ________

________ Physician Signature

________ Date

Physical Activity Now :

☐ None ☐ Little ☐ Moderate ☐ Very Active

Can you climb stairs? ☐ No ☐ Yes, number? ☐ 1 ☐ 2 ☐ 3 ☐ 3+

Medical History/Illnesses requiring Hospitalization:

List & Date: ______________________________

____

____

Previous Surgeries/Procedures (Including pacemaker, AICD, implants etc:

List & Date: ______________________________

____

____

____

Physical Information:

DO YOU WEAR/HAVE?

☐ No ☐ Yes Glasses ☐ No ☐ Yes Contact Lenses ☐ No ☐ Yes False Eyelashes

☐ No ☐ Yes Removable Dentures/Partials

☐ No ☐ Yes Non-removable dental work, such as a veneer, crown/cap, bridge, post and/or implant

☐ No ☐ Yes Loose or chipped teeth

☐ No ☐ Yes Current dental work in-progress

☐ No ☐ Yes Difficulty with movement of your head or neck

☐ No ☐ Yes False eye (s)

☐ No ☐ Yes Major physical or congenital defect(s): Please explain: ______________________________

☐ No ☐ Yes Difficulty opening you mouth

☐ No ☐ Yes Difficulty hearing ☐ No ☐ Yes Do you wear hearing aids?

Allergies/Drug Reactions:

☐ No ☐ Yes Latex Allergy/Intolerance: Explain: ______________________________

☐ No ☐ Yes Medication Allergies/Intolerances: List & explain: ______________________________

____

☐ No ☐ Yes Food Allergies/Intolerance: List & Explain: ______________________________

____

☐ No ☐ Yes Contrast Media (Iodine Dye) Reaction Explain: ______________________________

Current Medications:

INCLUDING "OVER-THE-COUNTER" AND HERBAL MEDICATIONS ☐ See attached list

List names & doses of any medications/herbals you take now or have taken in the last 6 months.

____

____

____

______________________________ ______________________________

Patient / Responsible Party Signature Date