

**PATIENT TO  
COMPLETE AND BRING  
THE DAY OF SURGERY**

**Facility Use Only:**  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_  
 Pre-Op Vitals: BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_ O2 Sat \_\_\_\_\_ Glucose \_\_\_\_\_ (Ref:100-200mg/dl)  
 NPO x 8 Hrs: YES \_\_\_\_\_ NO \_\_\_\_\_ Meds Taken Today \_\_\_\_\_

**PRE-ANESTHESIA HEALTH HISTORY**  
 Please Complete This Form Front and Back

**PLEASE CHECK**

**YES NO**

- Are you **ALLERGIC** to anything? Name medications and type of reactions (include latex rubber products, sulfites and food preservatives). \_\_\_\_\_
- Are you taking any **MEDICATIONS**? (Include prescription, over the counter, eye drops, inhalers and herbal medications). \_\_\_\_\_

MEDICATION	DOSE	HOW OFTEN?	LAST TAKEN?

**NOTE: IF YOU HAVE BEEN TAKING ANY ILLICIT (STREET) DRUGS, PLEASE TELL THE ANESTHESIOLOGIST. THIS IS IMPORTANT FOR YOUR SAFETY.**

**PLEASE CHECK**

**YES NO**

- Have you had previous **SURGERIES**? What anesthetics (local, block, spinal, epidural, general, awake or asleep)?
- | SURGERY | YEAR  | ANESTHESIA |
|---------|-------|------------|
| _____   | _____ | _____      |
| _____   | _____ | _____      |
| _____   | _____ | _____      |
- Can you climb a flight of stairs? 0 \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 or more? \_\_\_\_\_
- Have you ever had problems with anesthetics (nausea, vomiting, malignant hyperthermia)? \_\_\_\_\_
- Has anyone in your family had unusual reactions to anesthetics? \_\_\_\_\_

**PLEASE CHECK**

**YES NO**

**BELOW PLEASE CIRCLE THOSE THAT PERTAIN TO YOU:**

- Irregular Heart Beat / Heart Disease / Heart Valve Disease / Mitral Valve Prolapse \_\_\_\_\_
- Heart Attack / Angina / Chest Pain / Fainting \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Do you have a Cold / Cough / Asthma (Wheezing)? \_\_\_\_\_
- Lung Disease / Difficulty Breathing / Sleep Apnea \_\_\_\_\_
- Tobacco, How Much, How Long? Quit? \_\_\_\_\_
- Frequent Headaches / Stroke / Neurologic Disease \_\_\_\_\_
- Nervous Disorder, Seizures \_\_\_\_\_
- Diabetes / Thyroid Disease \_\_\_\_\_
- Kidney Disease / Liver Disease \_\_\_\_\_
- Infectious Disease (Hepatitis, HIV, TB, etc.) \_\_\_\_\_
- Heartburn, Gastritis, Esophageal Reflux, Hiatal Hernia, Ulcer \_\_\_\_\_
- Drink Alcoholic Beverages, How Much? \_\_\_\_\_

**PRE-ANESTHESIA HEALTH HISTORY**

*Please Complete This Page*

**PLEASE CHECK**

**YES NO**

**BELOW PLEASE CIRCLE THOSE THAT PERTAIN TO YOU:**

- Drug Use \_\_\_\_\_
- Arthritis / Rheumatism, Where? \_\_\_\_\_
- Difficulty Opening Mouth or Moving Neck \_\_\_\_\_
- Dentures, Chipped Loose Teeth, Special Dental Work \_\_\_\_\_
- Bleeding / Blood Transfusion / Bruising / Sickle Cell / Clotting Problems \_\_\_\_\_
- Contact Lenses / Glaucoma \_\_\_\_\_
- If you are not here related to a pregnancy are you possibly **pregnant?** \_\_\_\_\_

**IS THERE ANYTHING ELSE WE SHOULD KNOW?** \_\_\_\_\_

**Acknowledgement of Risks of Anesthesia**

Modern anesthesia is safe and usually well tolerated. However, even in experienced and competent hands, complications can occur. Minor problems include nausea and vomiting, headache, and injury to vocal cords, teeth and dental work. Serious complications include nerve injury, damage to one or more of the vital organs, even major disability or death. Other complications can occur. Although major complications of anesthesia are fortunately rare in healthy people, some types of health problems increase the risk of such occurrences. Therefore, it is important that you fully and accurately complete the health history questionnaire: "Pre-Anesthesia Health History."

Prior to surgery, an anesthesiologist will talk with you. During this preoperative visit, you are encouraged to discuss to your satisfaction the recommended anesthesia, the possible alternatives, as well as a more detailed discussion of the risks of anesthesia mentioned above. Please ask as many questions as you feel necessary in order to assist you in making an informed decision.

Your signature on this page indicates your acknowledgement that risk of complication always exists as a result of anesthesia management.

If you have questions, please ask your anesthesiologist to answer them.

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_  a.m.  p.m.

**Signature:** \_\_\_\_\_  
**Patient/Legal Representative**

**Reviewed by Anesthesiologist Signature:** \_\_\_\_\_ **Date/Time:** \_\_\_\_\_