Scripps Mercy Surgery Pavilion

A Partnership of Scripps Mercy Hospital and Physicians

PATIENT TO COMPLETE AND BRING THE DAY OF SURGERY

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). ____________________________________

____

PLEASE CHECK

YES NO ***BELOW PLEASE CIRCLE THOSE THAT PERTAIN TO YOU*:**

☐ ☐ Irregular Heart Beat / Heart Disease / Heart Valve Disease / Mitral Valve Prolaspe

☐ ☐ Heart Attack / Angina / Chest Pain / Congestive Heart Failure (CHF) / Pacemaker / Fainting

☐ ☐ High Blood Pressure

☐ ☐ Deep Vein Thrombosis (DVT) active / History of DVT - when: ____________________

☐ ☐ 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 / OTHER ________________________________

☐ ☐ Heartburn / Gastritis / Esophageal Reflux / Hiatal Hernia / Ulcer

☐ ☐ Drink Alcoholic Beverages, How Much? ____

PLEASE CHECK

YES NO

☐ ☐ Have you had previous **SURGERIES?** What anesthetics (local, block, spinal, Epidural, general, awake or asleep)?

SURGERY	**YEAR**	**ANESTHESIA**

PRE-ANESTHESIA HEALTH HISTORY
Please Complete This Page

☐	☐	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:
☐	☐	Drug Use ____
☐	☐	Arthritis / Rheumatism, Where? ______________________________
☐	☐	Difficulty Opening Mouth / 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**?

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

☐ No medications taken

PLEASE BRING THE COMPLETED LIST OF MEDICATIONS, DOSES, AND DATE LAST TAKEN

IS THERE ANYTHING ELSE WE SHOULD KNOW? _______________________________________

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Date:_________________________ **Time:** _________________________ ☐ **a.m.** ☐ **p.m.**

Signature: ____
Patient/Legal Representative