Scripps Mercy Surgery Pavilion

A Partnership of Scripps Mercy Hospital and Physicians

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 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**? If YES, please bring a list including dose and how frequently you take them. (Include prescription, over the counter, eye drops, inhalers and herbal medications).

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 PLEASE CHECK THOSE THAT PERTAIN TO YOU:

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

☐ ☐ 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? _____

PLEASE CHECK

YES	NO	PLEASE CHECK 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? _____

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

Signature: _____
Patient/Legal Representative

Reviewed by Anesthesiologist Signature: _____ **Date/Time:**_____