

**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 Prolapse

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? _____

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

Signature: _____
Patient/Legal Representative