Anesthesia Preoperative Patient History

Please Complete and BRING WITH YOU to Your Anesthesia Appointment

Patient Name:

Date of Birth:

Phone Number:

Kind of Surgery You are Having:

Date of Your Surgery: (if known)

Name of Doctor Doing the Surgery:

Name of Your Primary Care Doctor:

List all surgeries or procedures you have had and the dates of when you had them.

Surgery or Procedure	Date

List any allergies you have to medications, latex, food and any other allergies.
Also list your reactions to them.

✓	**Check off any TESTS that you have already had. Give the location of where you had the test done and the date you had the test.**

Bring all test results and reports to your appointment. You may not need these tests. **DO NOT** get these tests just because you may be having surgery. If you already had these tests done bring them to your appointment.

	Name of Test	**Location of Test**	**Date**
	ECG		
	Sleep Study		
	Blood Work		
	Stress Test		
	Echo (Ultrasound Of Heart)		
	Pulmonary Function Test (Breathing Test)		

List any other tests you have had. Give the location of where you had the tests done and the date of the test.

Name of Test	**Location of Test**	**Date**

List all medications you have taken in the last month. Include over-the-counter drugs, inhalers, herbals, dietary supplements and aspirin or you can bring all of your medication bottles.

Name of Medication or Other Drugs	**The Dose:** How much you take and how many times a day you take it

✓	**Have you or anyone in your family had serious problems with:** (Check all that apply)
	Nose Bleeds
	Bleeding with Tooth Extractions
	Bleeding After Surgery

✓	**Have you ever had problems with anesthesia or surgery?** (Check all that apply)	Yes ○	No ○
	Severe Nausea or Vomiting		
	Malignant Hyperthermia (in family who are blood relatives or in yourself)		
	Breathing Difficulties		
	Problems With Placement of a Breathing Tube		

Do you have any of the following?		
Chipped or Loose Teeth, Dentures, Partials	Yes ○	No ○
Problems Moving Your Neck	Yes ○	No ○
Problems Opening Your Mouth	Yes ○	No ○
Women: Could you be pregnant?	Yes ○	No ○
Women: When did your last menstrual period begin?	**Date:**	

✓	**Have you had any of the following problems with your heart or blood vessels?** (Check all that apply)		
	Heart Failure (fluid in your lungs)		Chest Pain or Pressure
	Murmur or Heart Valve Problem		Blockage of Arteries
	Heart or Blood Vessel Surgery		Palpitations/Irregular Heart Beat
	Heart Attack or Heart Stents		Implanted Device (ICD, pacemaker)

Are you on a **blood thinner?** Examples: Aspirin, Coumadin (warfarin), Plavix (clopidogrel), Effient (prasugrel), Pradaxa (dibigatran), Xeralto (rivaroxaban), Eliquis (apixaban)	Yes ○	No ○
Can you walk up one flight of stairs without stopping?	Yes ○	No ○
Are you **limited** in the things you can do during the day because of your **physical ability?**	Yes ○	No ○
Do you have **diabetes?**	Yes ○	No ○

✓	**Have you had any of the following problems with your lungs or your chest?** (Check all that apply)			
	Shortness of Breath			Asthma
	COPD or Emphysema			Pulmonary Fibrosis
	High Blood Pressure in the Lungs (pulmonary hypertension)			TB (tuberculosis)
	Cystic fibrosis			Sarcoidosis

Question	Yes	No
Have you taken steroids (prednisone or cortisone) in the last year?	Yes O	No O
Do you use **oxygen** at home during the day or night?	Yes O	No O
Do you **snore loudly** (louder than talking or loud enough to be heard through closed doors)?	Yes O	No O
Do you often feel **tired, fatigued, or sleepy** during the daytime?	Yes O	No O
Has anyone observed you **stop breathing** during your sleep?	Yes O	No O
Do you have or are you being treated for **high blood pressure?**	Yes O	No O
Do you have **sleep apnea?**	Yes O	No O

Question		
Have you ever smoked?	Yes O	No O
What was the date you quit smoking?	Date:	
How many packs a day did you smoke?	Number of Packs:	
How many years did you smoke?	Number of Years:	
Do you still smoke?	Yes O	No O
How many packs a day do you smoke?	Number of Packs:	
Do you drink alcohol?	Yes O	No O
How much do you drink in an average week?	Number of drinks:	
Have you ever had **alcohol withdrawal symptoms or seizures**?	Yes O	No O
Do you use or have you ever used any **street (illicit) drugs, marijuana or opioids not prescribed for you?** If yes, please list type of drugs	Yes O	No O

Have you ever been treated with **chemotherapy or radiation therapy?** If yes, list treatment and date of last treatment.	Yes ○	No ○

Name of Treatment	Last Treatment Date

✓	**Have you had any of these problems with your blood?** (Check all that apply)
	Leukemia or Lymphoma
	Hemophilia
	Blood Clots
	Anemia
	Sickle Cell Disease
	Blood Transfusion in the past
✓	**Have you had problems with your** (Check all that apply)
Liver	
	Cirrhosis
	Hepatitis A, B, or C
	Jaundice
Kidneys	
	Kidney Stones
	Kidney Failure or Dialysis
Digestive System	
	Frequent Heartburn
	Hiatal Hernia
	Ulcers
Back, Neck or Jaw	
	TMJ
	Rheumatoid Arthritis
	Herniated Disk or Back Problems
	Thyroid Problems

Nerves or Muscles	
	Seizures
	TIA or Stroke
	Facial, Leg or Arm Weakness
	Neurologic Disorder, Examples: Multiple Sclerosis, ALS, Alzheimer’s
	Muscular Disorder, Examples: Myasthenia Gravis, Muscular Dystrophy
	Problems With Hearing, Vision or Memory
	Severe Anxiety or Depression
	Chronic Pain

	Yes	No
Do you have Glaucoma?	○	○

Please list any additional medical illnesses you have that were not noted above.

	Yes	No
Do you have any comments or questions for the anesthesiologist?	○	○

Please write any questions or comments you have: