First Name: _____ Doctor: _____

Last Name: _____ Procedure (location and laterality):

Date of Birth: _____ _____

Patients receiving anesthesia are required to have a driver.

Name of person providing ride home (include relationship to you): _____

Phone number of ride home: _____

Is your primary language English? Yes If no, list primary language _____

Social History

1. What is your tobacco status? **Never used Former user Current user**

Reminder: Do not use 12hrs prior to procedure.

2. Do you drink beer, wine or liquor? Yes No

   If yes, number of days per week & drinks per day? _____

3. History of alcohol abuse? Yes No

4. History of using recreational or street drugs (marijuana, cocaine, methamphetamines, other)? Yes No

   If yes, how often: _____Which kind_____

Reminder, do not use 24hrs prior to surgery in order to sign consent forms and prevent complications.

Physical Activity

1. Do you have a history of falls in the last 6 months? Yes No
2. Do you used any assisted devices (ex: wheelchair, walker cane)? _____

Physician Information

Do you have a primary care physician? **Yes** Name: _____ **No**

Are you treated on a regular basis by a specialist (e.g. cardiologist, neurologist)? **Yes No**

Name and specialty: _____

General Information

Height: _____ **Weight:** _____

1. Do you wear glasses? Yes No
2. Do you wear contact lenses? Yes No
3. Do you use hearing aids? Yes No **Right/Left/Both**
4. Do you have **body piercings**? Yes No **If yes, What and where**: _____
5. Do you have dental work other than fillings? Yes No

   Dentures Upper/lower, Partials Upper/lower Other: _____

   (Please remove for day of surgery)
6. Do you have artificial joints implanted? Yes No **If yes, What and where**: _____
7. Do you have metal plates, screws, rods, wires or pins implanted? Yes No

   If yes, What and where: _____
8. Do you have an internal nerve stimulator? Yes No

Past Surgical/Anesthesia History

Have you had any complications related to anesthesia? Yes No

Do you currently have a central venous line, such as chemo and/or antibiotic port, PICC line, or dialysis catheter? Yes No

Have you had any **Complications** with medical procedures that required anesthesia? Yes No
What were the complications: _____

Previous Surgeries

Type of Surgery	Date, If known

Family History

	Yes	No	If yes, list relationship to you
Cancer	○	○	
Blood Clots	○	○	
Malignant Hypothermia	○	○	
Anesthesia complications	○	○	
Other	○	○	

Do you or a family member have a history of...
Malignant hyperthermia? (life threatening high temperature under anesthesia) Yes No
Pseudocholinesterase deficiency? (Prolonged paralysis from muscle relaxants) Yes No

Do you have a history of…
Difficult intubation? (Difficulty placing breathing tube for general anesthesia) Yes No
Motion sickness? Yes No
Postoperative nausea & vomiting (PONV) Yes No
Other serious adverse reactions to anesthesia medications? Yes No

History	Yes	No
Do you have high blood pressure?	○	○
Cardiac: Any history of heart problems?		
Any heart surgery or procedures? (stents, CABG, Angioplasty) If yes, please explain: _____	○	○
Do you have an abnormal heart rhythm / heart murmur	○	○
Do you have a pacemaker or AICD? If yes, make/ model and when last interrogated: _____	○	○
History of congestive heart failure?	○	○
Pulmonary: Any history of breathing problems?		
Do you have asthma? If yes, when was your last asthma attack?	○	○
Do you have emphysema / COPD?	○	○
History of pneumonia?	○	○
Do you have sleep apnea? If yes do you wear a CPAP or BPAP	○ ○	○ ○
Any home oxygen use?	○	○
Do you ever feel short of breath? What causes this standing, walking, going up stairs? _____	○	○
Do you ever feel short of breath at rest?	○	○
Do you ever feel short of breath when you lie flat?	○	○
Digestive History		
Do you have acid reflex (GERD), heartburn?	○	○
Ever had a hiatal hernia?	○	○
Ever had a bleeding ulcer?	○	○
Have you ever had hepatitis? If yes, what type and when? _____	○	○
Do you have jaundice or liver failure?	○	○
Renal History		
Do you have kidney failure? If yes, are you on dialysis (Include days of the week)? _____	○	○
Other renal conditions? Explain here: _____	○	○
Endocrine History		
Do you have diabetes? Type I Type II	○ ○ ○	○ ○ ○
Do you have a thyroid condition? If yes is it hypo or hyper? _____	○ ○	○ ○

Hematologic (Blood) History		
Do you have anemia?	○	○
Do you have any bleeding history? If yes, explain: _____	○	○
Ever had a blood clot (DVT) If yes, location and year:_____	○	○
Ever had AIDS?	○	○
Musculoskeletal		
Do you have arthritis? If yes include location:	○	○
Do you have fibromyalgia?	○	○
Do you have lupus?	○	○
Do you have any back or neck problems? If yes explain: _____	○	○
Do you have any disabilities? If yes explain: _____	○	○
Neurological History		
Ever had a stroke / TIA? Include any lasting effects and year of occurrence: _____	○	○
Ever had a seizure?	○	○
Ever had a head injury with loss of consciousness (fainting or dizzy spells)	○	○
Do you have migraines?	○	○
Mental Status		
Do you have anxiety?	○	○
Do you have depression?	○	○
Do you have ADD or ADHD?	○	○
Do you have bi-polar disease?	○	○
If you are female, could you be pregnant? If not did you have a hysterectomy or go through menopause?	○	○
Have you had any recent exposure to any infectious diseases such as MRSA/ VRE? If yes explain: _____	○	○
Have you recently had a cold, flue, or infections? Explain symptoms: _____	○	○
Has anyone you are in close contact with had recent cold, flu, fever, cough? List relationship to you and explain symptoms: _____	○	○

Please list any other significant medical problems or recent hospitalizations not mentioned above

_____

_____

_____

ALLERGIES	REACTION

Medications, prescription, over the counter and vitemans or supplements

NAME	DOSE	HOW OFTEN TAKEN	WHEN TAKEN	WHY TAKEN