THIS SECTION TO BE COMPLETED BY NURSING STAFF:

Weight _____lbs _____kg Height _____

Pre-op Vitals: BP _____ P _____ R _____ SPO2 _____ T _____

Please provide the following information for review by your anesthesiologist. This information will be used to plan a safe and effective anesthesia.

NAME: _____ SURGEON: _____ DATE: _____

Have you now or in the past had any of the following: (Check all that apply.)

___ Bronchitis
___ Emphysema
___ Asthma
___ Hayfever
___ Sinus infection
___ Tuberculosis
___ Abnormal chest x-ray
___ Smoking history ___ yrs
_____ packs/day
_____ yrs quit
___ Tobacco/Nicotine products type_____
___ Shortness of breath
___ Home O2 @ ____ liters
___ Sleep Apnea/Snoring
___ CPAP ___BIPAP

___ Cough, cold, sore throat (in last 2 weeks)
___ High blood pressure
___ Heart attack _____ yr.
___ Heart murmur
___ Chest pain/Angina
___ Heart disease
___ Bleeding tendency
___ Abnormal ECG
___ Blood clots
___ Congestive heart failure
___ Pacemaker
___ Anemia
___ Diabetes
___ Thyroid disease
___ Hx motion sickness
___ Muscle disorders
___ Caffeine consumption

___ Kidney disease
___ Jaundice, hepatitis
___ Liver disease
___ Cancer _____
___ Stomach/bowel problem
___ Acid reflux
___ Convulsions, Epilepsy, seizures.
___ Stroke
___ Transient Ischemic Attacks (TIA'S)
___ Fainting
___ Back pain, slipped disc, sciatica.
___ Arthritis
___ Broken bones of face, back or neck.
___ Alcohol consumption

___ Previous transfusion of blood or blood products.
___ Refused blood transfusion
___ Jehovah's Witness
___ Relative with severe reaction to anesthesia
___ Loose teeth or caps
___ Dentures or bridges
___ Contact Lens
___ Glasses
___ Hard of hearing
___ Hearing aide
___ Body piercing
___ Depression
___ Mental Illness
___ Neural Defect (i.e. Spinal bifida)

ARE YOU PREGNANT? YES NO N/A

ARE YOU BREAST-FEEDING? YES NO N/A

List past surgeries below.	Anesthesia type (Circle)	Complications	Year/Date
	Local Spinal General		
	Local Spinal General		
	Local Spinal General		
	Local Spinal General		
	Local Spinal General		
	Local Spinal General		
	Local Spinal General		
	Local Spinal General		

ALLERGIES/REACTIONS	
Allergen	What Happened**?**
(If None Please Indicate)	

LIST MEDICATIONS, VITAMINS, HERBAL SUPPLEMENTS	
Name	Dose & Frequency

✶✶✶CONTINUED ON BACK✶✶✶

Circle

Y N Are you a diabetic?
Tell us about your diabetic medication/insulin routine _____
_____
_____

Y N Do you have a latex allergy?
Y N Have you had an allergic reaction local sensitivity or itching experience following exposure to latex products such as balloons or condoms?
Y N Have you experienced shortness of breath or wheezing after blowing up balloons or after dental visits.
Y N Have you experienced an allergic reaction or local sensitivity to bananas, avocados, nuts or kiwi?

PLEASE READ AND SIGN: Answers to the above represent a true and complete history to the best of my knowledge. I am aware that while anesthesia is a safe and low risk procedure, all anesthetics have a risk of complications. These include, but are not limited to, dental damage, seizures, nerve injury, headache, respiratory complications, heart attack, major organ damage, fetal demise, and even death. I understand the above, and agree to proceed.

_____
Patient Signature Relationship Date