ANESTHESIA HEALTH HISTORY

Preferred Name/Nickname:	Height	Weight	BMI

Allergies & Medications: see Allergy and Medication Reconciliation form

Yes	No	Previous surgeries? Please list with approximate year and type of anesthesia, if known.
Yes	No	Have you or anyone in your family had a reaction to anesthesia? (i.e. nausea, vomiting, high fever, malignant hyperthermia.)

Yes	No	**Please circle any of the following that apply to you**	Yes	No	**Please circle any of the following that apply to you**
		Heart attack/Angina/Chest pain/Heart disease/Mitral valve prolapse			Heartburn/Reflux/ Ulcers/ Hiatal hernia
		High blood pressure/Fainting			Hepatitis/Jaundice/ Liver problems
		Irregular heart beat/Pacemaker/AICD			Alcohol? How much?
		Asthma (Wheezing)/Cough/TB Breathing problems			Infectious diseases? MRSA? Antibiotics?
		Sleep apnea, CPAP? Yes/No			Dentures/Chipped or loose teeth/Special dental work
		Smoking? Yes/No How much? Quit?			Difficulty opening mouth/ TMJ/ Stiff neck
		Stroke/TIA/Seizures (Epilepsy) last one?			Drug use/Dependency: It is important for your safety to inform the anesthesiologist
		Headaches/Neurologic-nervous disorder/Anxiety/Depression			Arthritis? Where?
		Diabetes/Kidney or bladder problems/ Thyroid	Other info about you that you would like to share?		
		Bleeding/Bruising/Clotting problems/ Sickle cell disease	**No Changes since last visit – DOS: _____** **Patient Initials: _____**		

_____ _____ _____

Patient/Legal Guardian's Signature **Relationship** **Date**

ANESTHESIA PRE-OPERATIVE ASSESSMENT

Admission Assessment and Pre-op vital sign reviewed

Airway:_____ Heart:_____

Chest: _____ Other:_____

Labs: _____ EKG: _____

ASA 1 2 3 4

Plan: GA MAC Spinal R L _____ Block (Requested by the surgeon for post-op analgesia)

I have discussed the anesthesia plan with the patient/guardian who agrees.

_____

_____

_____

_____ _____ _____

Anesthesiologist Signature Date Time