Surgical Arts Center

PATIENT ANESTHESIA & MEDICAL HISTORY

Please complete the following information. This information will assist the anesthesia staff at Surgical Arts Center in making decisions regarding your care while a patient at the Center.

Please place a check if you now have, or have ever had, any of the following:

Respiratory (breathing problems)	Yes	No
Recent cold, bronchitis, or pneumonia		
Sleep apnea £ Loud snoring £		
Use CPAP at night		
Asthma or wheezing		
Emphysema/COPD or chronic bronchitis		
Chronic cough		
Tuberculosis		
Other:		
Hematologic (blood problems)	**Yes**	**No**
Anemia (low blood count)		
Easy or prolonged bleeding or bruising		
Other:		
Psychological (mental health problems)	**Yes**	**No**
Anxiety £ Depression £		
Panic disorder		
Post-traumatic stress disorder (PTSD)		
ADHD		
Bipolar disorder		
Other:		
Musculoskeletal	**Yes**	**No**
Chronic pain		
Weakness		
Any problems moving your neck		
Osteoarthritis		
Rheumatoid arthritis		
Other:		
Anesthesia History	**Yes**	**No**
Nausea/vomiting		
Malignant Hyperthermia		
history difficult IV access		
history difficult intubation (breathing tube)		
Slow awakening		
Family history of major complications		
Other:		

Cardiovascular (heart or circulatory problems)	Yes	No
Fast or irregular heart beat		
Angina/chest pain		
Heart valve problems		
High blood pressure		
Low blood pressure		
Heart attack Year:		
High cholesterol		
Heart failure		
Coronary artery disease		
Stents in the heart		
Previous heart or lung surgery		
Pacemaker £ Defibrillator £		
Blood clots/ phlebitis/ pulmonary embolism		
Shortness of breath after climbing one flight of stairs or doing moderate intensity housework		
Other:		
Gastrointestinal (digestive problems)	**Yes**	**No**
Hepatitis or yellow jaundice		
Chronic liver disease		
Acid reflux/ GERD/heartburn		
Ulcers		
Ulcerative colitis £ Crohns £		
Other:		
Social History	**Yes**	**No**
Smoking: Cigarettes £ Vape £		
Average packs per day:		
Number of years: Quit:		
Alcohol Frequency:		
Recreational drugs:		
history of addiction		
Dental	**Yes**	**No**
Any problems opening your mouth		
Dentures or bridges		
Veneers £ Caps/crowns £		
Loose teeth		

Neurologic Problems (nerve problems)	Yes	No
Stroke £ TIA (mini-stroke) £		
Multiple sclerosis £ Polio £		
Epilepsy/seizures		
Fainting		
Neuropathy of arms/legs		
Motion sickness		
Other:		
Endocrine Problems	**Yes**	**No**
Thyroid Overactive £ Underactive £		
Diabetes Insulin £ Pills only £		
Other:		
Kidney Problems	**Yes**	**No**
Chronic kidney disease		
Dialysis		
Other:		
Cancer	**Yes**	**No**
Cancer		
Site(s):		
Previous chemotherapy		
Previous radiation		
Previous surgery		
Eyes/Ears	**Yes**	**No**
Poor hearing		
Poor vision		
Glaucoma		
Other:		
Pregnancy	**Yes**	**No**
Is there any chance you could be pregnant?		

A YES response will require will require a pregnancy test on the day of your procedure.

Please list all of your previous surgeries and procedures:

The information I have provided is true to the best of my knowledge.

Patient Printed Name _____ Patient Signature _____ Date _____

Allergies and Sensitivities **NKDA**

Patient Sticker

Drugs	Reaction

	Yes	No	Reaction
Latex			
Contrast			
Tape			
Iodine			
Eggs			

Women only

	Uncertain	Yes	No		Yes	No		Yes	No
Are you pregnant?				Are you currently breastfeeding?			Are you menopausal?		
Are you recently pregnant?				Date of last menstrual period:			If yes, for how long:		

Surgical/Anesthesia History

Please list all previous surgeries or procedures requiring anesthesia:

Have you had any previous surgery at Suburban? Yes £ No £

Have you had any problems or complications with anesthesia? Yes £ No £

If yes, explain:

Have any of your blood relatives had major problems or complications with anesthesia such as malignant hyperthermia or pseudocholinesterase deficiency? Yes £ No £

If yes, explain:

Pain Screening

Do you have chronic pain? Yes £ No £

If yes, where is your worst pain located?

Rate the severity of your pain:

(0 = no pain, 10 = worst imaginable pain)

Do you take narcotic pain medications at least several times per week? Yes £ No £

Substance Screening

Do you smoke: Yes £ No £	Do you drink alcohol: Yes £ No £	Do you now, or have you ever, used recreational or IV drugs? Yes £ No £
If yes, how much per day:	If yes, how frequently?	
Total number of years smoked:	If yes, how much at a time?	If yes, which drugs and last used?
If you quit smoking, how long ago?	If recovering alcoholic, for how long?	

Interview with: _____ Date _____ Time _____

Name of Patient or Caretaker

Interview by: _____ Date _____ Time _____

Nurse Printed Name Nurse Signature