Pre-Anesthesia Health History Questionnaire (Confidential)

Patient Name: _____ Today's Date: _____

Patient Information:

Date of Birth: ____ /____ /_____ Age: _____ Height:_____ Weight:_____ Contact Phone #: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip:_____

Name of person responsible for patient:_____ Relationship:_____ Drivers License #:_____

Address: _____ City: _____ State: _____ Zip:_____

Email: _____ Cell Phone #: (_____) _____-_____ Home Phone #: (_____) _____-_____

Doctors:

Patient's Primary Care Physician or Pediatrician: _____ Phone #: (_____) _____-_____

Date of last physical exam/ Checkup: _____ Fax #: (_____) _____-_____

Names of other Physicians/ Specialists seen: _____ Phone #: (_____) _____-_____

Date of Last Visit: _____ Type(s) of Specialist:_____ Fax #: (_____) _____-_____

Health History:

Date Patient was Last Sick:_____ (Circle any Symptoms:) Cough, Cold, Fever, Runny Nose, Sore Throat, Ear Infection

Please list any other Symptoms:_____

Have you (has the patient) ever been to the emergency room? . .Yes No For What Reason _____

Have you (has the patient) ever been in the hospital? . . . . . Yes No For What Reason _____

Have you (has the patient) ever had surgery or anesthesia?. . . . . Yes No For What Reason _____

Patient's Medical History: Please circle the appropriate response for the following questions:

Heart/Blood Vessels

Heart murmur…….	Yes	No
Congenital heart defect……..	Yes	No
Artificial heart valve…….	Yes	No
Rheumatic fever…….	Yes	No
Rheumatic heart disease…….	Yes	No
Heart valve damage……	Yes	No
High blood pressure…….	Yes	No
Heart attack…….	Yes	No
TIA / Stroke…….	Yes	No
Heart surgery…….	Yes	No
Angioplasty…….	Yes	No
Vascular surgery…….	Yes	No
Pacemaker…….	Yes	No
Coronary heart disease…….	Yes	No
Congestive heart failure…….	Yes	No
Angina pectoris…….	Yes	No
Chest pain……	Yes	No
Irregular heartbeat…….	Yes	No
Rapid heartbeat…….	Yes	No
Other heart / vessel disorder.	Yes	No

Blood

Blood clots or thrombosis…	Yes	No
Anemia……	Yes	No
Sickle cell disease / trait……	Yes	No
Hemophilia……	Yes	No
Bleeding disorder……	Yes	No
Bruise easily for no apparent reason……	Yes	No
Other blood disorder……	Yes	No

If yes, what type: _____

Nervous System

Epilepsy……..	Yes	No
Seizure disorder…….	Yes	No
Multiple sclerosis……..	Yes	No
Trigeminal neuralgia……..…	Yes	No
Chronic pain……..	Yes	No
Anxiety/depression……..	Yes	No
Alzheimer's disease……..	Yes	No
Dementia……	Yes	No
Psychiatric treatment……..	Yes	No
Psychological counseling…..	Yes	No
Persistent numbness/tingling.	Yes	No
Other nervous system disorder.	Yes	No

Head & Neck

Glaucoma……..……..	Yes	No
Chronic sinusitis……	Yes	No
Injury to head, neck, face, or teeth……	Yes	No
Headaches……..	Yes	No
Unexplained visual change…	Yes	No
Frequent or severe nosebleeds……..……..	Yes	No
Persistent sore throat or hoarseness……..……..	Yes	No
Difficulty swallowing…..….	Yes	No
Other head / neck disorder.....	Yes	No

Endocrine

Diabetes Type I or II……..	Yes	No
Low thyroid……..	Yes	No
Other thyroid condition……..	Yes	No
Cushing's syndrome……..	Yes	No
Parathyroid condition..……..	Yes	No
Pituitary condition……..	Yes	No
Other endocrine condition…..	Yes	No

Musculoskeletal

Sjogren's syndrome……..	Yes	No
Arthritis……..	Yes	No
Artificial joint……..	Yes	No
Fibromyalgia/ rheumatitis...	Yes	No
Chronic back pain……..	Yes	No
Other bone/muscle disorder...	Yes	No

Respiratory

Tuberculosis……..	Yes	No
Asthma……..	Yes	No
Bronchitis……..	Yes	No
Pneumonia…….	Yes	No
Emphysema……..……..	Yes	No
Cough up bloody sputum…..	Yes	No
Shortness of breath……..…..	Yes	No
Wheezing……..……..…….	Yes	No
Loud snoring	Yes	No
Had a sleep study	Yes	No
Sleep apnea…….	Yes	No
Other respiratory……..……..	Yes	No

Urinary Tract

Kidney disease……..……..	Yes	No
Renal dialysis……..……..	Yes	No
Venereal disease……..……..	Yes	No
Sexually transmitted disease..	Yes	No
Urinary Tract Infection (UTI)	Yes	No
Other urinary disorder……..	Yes	No

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Digestive System

Hepatitis……..……..	Yes	No
Liver disease……..	Yes	No
Cirrhosis of the liver……..	Yes	No
Ulcers……..……..	Yes	No
Jaundice……..	Yes	No
Frequent heartburn…..……..	Yes	No
GERD……..……..	Yes	No
Acid reflux.	Yes	No
Frequent nausea/vomiting . . .	Yes	No
Postoperative nausea/ vomiting	Yes	No
Other digestive disorder.	Yes	No

Cancer History

Leukemia……..……..	Yes	No
Benign tumors/growths……..	Yes	No
Cancer……..……..	Yes	No

If yes, what type: _____
If yes, treatment:
[ ] Surgery
[ ] Radiation
[ ] Chemotherapy
[ ] Hormone therapy

Other cancer……..……..	Yes	No

Skin History

Any burns to skin?	Yes	No

If so, where?_____

Eczema	Yes	No
Other skin disorder?	Yes	No
Current cuts or bruises?	Yes	No

If so, where?_____

Allergy History

Are you allergic to or have you ever had a bad reaction to the following:

Dental anesthetics…...……..	Yes	No
Penicillin……..……..	Yes	No
Sulfa drugs……..……..	Yes	No
Other antibiotics……..……..	Yes	No
Aspirin……..……..	Yes	No
Latex products……..……..	Yes	No
Egg or food……...……..	Yes	No
Other allergy……..…..……..	Yes	No

Family History

Has anyone in your family (grandparents, parents, siblings, children) ever had:

Problems with anesthesia	Yes	No
Malignant Hyperthermia?	Yes	No
Diabetes? ……..……..	Yes	No
Heart disease? ……..……..	Yes	No
Depression/anxiety? ……..	Yes	No
Tuberculosis? ……..…..	Yes	No
Bleeding disorder? …….....	Yes	No
Sudden unexplained death ...	Yes	No
Anything else that runs in the family? ……..	Yes	No

If yes, what?_____

Miscellaneous

Lupus erythematosus…….....	Yes	No
Organ transplant…….	Yes	No
Suppressed immune system..	Yes	No
Taken steroids……..……..	Yes	No
Taken prednisone / cortisone.	Yes	No
Taken prescription diet pills..	Yes	No

Use/used tobacco products…	Yes	No
Smoke……..……..	Yes	No
Used Marijuana	Yes	No
Chew tobacco……..…..	Yes	No
Drink alcoholic beverages…..	Yes	No

If yes, how much_____

Used methamphetamines.…..	Yes	No
Used amphetamine or speed..	Yes	No
Used cocaine or "crack" ...…..	Yes	No
Used other recreational drug..	Yes	No
Are you a recovering alcoholic or addict? ...……..	Yes	No

Other

Down syndrome…….	Yes	No
Developmental delay…….	Yes	No
Mental retardation…….	Yes	No
Cerebral palsy……	Yes	No
Autism……	Yes	No
ADHD……	Yes	No
Combative / aggressive….....	Yes	No
Self-abusive……	Yes	No
Surgical:		
VP shunt or revisions…….	Yes	No
Vagal nerve stimulator……	Yes	No
Blood transfusion…….....	Yes	No

Women Only

Are you pregnant? ……...…..	Yes	No
Is there a chance you could be pregnant? ……..	Yes	No
Are you nursing (breast-feeding)? …..……..	Yes	No

Circle the following drugs that you are (the patient is) taking or have taken		
Heart pills	Oral contraceptive	Antibiotics
Nitroglycerin	Steroids/Cortisone	Antihistamines
Digitals	Hormones	Cyclosporine A
Aspirin	Insulin	Tranquilizers
Blood thinners	Diabetic drugs	Sleeping pills
Blood pressure	Thyroid	Antidepressants

List all medications and doses that the patient is taken or have taken in the last 6 weeks

_____

_____

_____

_____

The information on this questionnaire is accurate to the best of my knowledge and withholding any information can result in injury and death. I understand that this information will be held in strictest of confidence and it is my responsibility to inform the Anesthesiologist of any changes in this patient's medical status at the earliest possible time.

_____

Signature of Patient/Parent **Date**

_____

Reviewed by: Dr. Joseph Ilustre Date