Anesthesia/Health Questionaire

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

	YES	NO		YES	NO
Problems with Anesthesia			Tuberculosis		
High Fevers after Anesthesia			Bronchitis, Asthma, Emphysema		
Loose Teeth / Dentures			Any problems with Sleep Apnea		
Glasses / Contact Lenses			Oxygen Dependent		
Aneurysms			If YES, how much? _____		
Seizures			☐ Day & Night ☐ At night ONLY		
Black Outs (syncope)			Hiatal Hernia / Nausea / Heartburn		
Stroke			Hepatitis / Jaundice		
High Blood Pressure (even if controlled)			Diabetes		
HEART PROBLEMS:			Thyroid Trouble		
Heart Attack			Blood Clotting problems		
Chest Pain			History of Bleeding / Anemia		
Irregular Heartbeat / Palpitations			Sickle Cell Disease		
Heart Failure			Any Neck or Back problem		
Heart Surgery			Are you pregnant now?		
Heart Valve Problems			Kidney Trouble		
Heart Stents? If yes, Date:			Are you on Dialysis?		
Do you have a Pacemaker			Autoimmune Disesase:		
Pacemaker with Defibrillator			Lupus / Rheumatoid Arthritis / other		
Brand:			**Family History of:** Colon Cancer		
Cardiac Cath in the last 18 months:			Esophageal Cancer		
Test completed @:			Stomach Cancer		
Echocardiogram in last 18 months:			History of alcohol or drug abuse		
(ultrasound x-ray of the heart)			History of Anxiety / Depression		
Test completed @:			Do you drink alcohol? How Often?		
Stress test in last 18 months:			How Often?		
Test completed @:			Do you smoke / Ever smoked?		
Height: _____ Weight: _____			Last smoked? _____ Year		
			How many cigarettes a day?		

Have you had a colonoscopy/endoscopy before? If yes, what year?

Drug/Latex/Tape Allergies:

Current Medicines:

Prior Surgeries (include year):

Primary Care Physician/Family Physician:

PRINT Patient Name **Date of Birth**

Patient Signature **Date**