Your Name: ______________________ Age: ______ Height ______ Weight ______

ALLERGIES to medication, drugs, food, or other substances: ______________________

Your Regular Physician: ______________________

MEDICATION: List **all prescription, over the counter and herbal medications** you are currently taking

Medication Name	Dose	How often

SURGERIES: List all previous surgeries

Date	type of surgery	Anesthesia Type: general	spinal	local

Please indicate yes, no or "?" (if unknown) and fill in the blanks. Circle or check the specific problems if they apply to you.

Y N ? I (the patient) have reviewed the medications listed above and they are correct.
Y N ? Do you need to visit your **medical doctor** more than once per year? Name: ______
Y N ? Have you had **any test of heart function** with in the past 5 years including treadmill stress test, EKG, or echocardiogram, or cardiac catheterization? When & Where? ______
Y N ? Have you been **hospitalized** in the past 5 years? If yes, why?
Y N ? Tobacco use: packs/day ______ x ______ yrs. Quit smoking ______ years ago.
Y N ? Have you or any close relative ever had any serious problems or unpleasant **reactions to anesthesia** or **surgery**? If yes, please describe: ______
Y N ? Family history of malignant hyperthermia (MH), muscle or neuromuscular weakness or disorder, unexplained dark urine, high fever or death after anesthesia
Y N ? Have you had a **recent cold**, flu, cough or sore throat?
Y N ? Do you have any heart or lung problem that seems to **limit your physical activity**?
Y N ? Has a dentist or anesthesia provider told you that there was **difficulty with your airway** or **mouth opening**?
Y N ? Do you have **shortness of breath** when climbing a flight of stairs?
Y N ? Do you have active **asthma**? Asthma or breathing problems in the past?
Y N ? Have you had any recent **new chest pain**?
Y N ? Have you had any recent **irregular heart beat?**
Y N ? Do you have any **dental problems** such as loose teeth or extensive dental work?
Y N ? Do you have known **diabetes, liver damage** or **kidney failure**?
Y N ? Do you drink **alcohol** daily? Amount ______
Y N ? Have you had **frequent heart burn,** difficulty swallowing, or episodes of spitting up swallowed food?
Y N ? Are you easily **nauseated,** have a "weak stomach", or a tendency to **motion sickness**?
Y N ? **MEN:** Do you have **prostate** problems or difficulty urinating?
Y N ? **WOMEN:** Is there any chance you could be **pregnant**?
Y N ? **WOMEN:** Do you have menstrual periods?
Y N ? Do you currently have **numbness** or **weakness** anywhere in your body?
Y N ? Do you have **back problems** such as frequent back pain, have pains down the legs (sciatica), curvature of the spine (scoliosis) or require chiropractor visits?

Check any of the following medical problems that you have now or have had in the past (if none, please check the "❑ **None**"):

RESPIRATORY: ❑ **None** in this category ❑ Emphysema ❑ Tuberculosis ❑ Chronic Bronchitis ❑ Repeated Pneumonia ❑ Sleep Apnea ❑ Supplemental Oxygen

HEART/ BLOOD VESSELS: ❑ **None** in this category ❑ Heart Valve problems including Mitral Valve Prolapse ❑ Heart Attack ❑ High Blood Pressure ❑ Angina (chest pain) ❑ Heart Murmur ❑ Rheumatic Fever ❑ Pacemaker ❑ Palpitations ❑ Irregular Heart Beat

DIGESTIVE URINARY, ABDOMEN: ❑ **None** in this category ❑ Ulcer ❑ Hiatal Hernia ❑ Hepatitis or Yellow Jaundice ❑ Liver Failure ❑ Kidney Failure

BLOOD/RELATED PROBLEMS: ❑ **None** in this category ❑ Prior Blood Transfusion ❑ Bleeding Difficulties ❑ Blood Clots in Lungs or Legs ❑ Cancer ❑ Leukemia

NERVES/JOINT PROBLEMS: ❑ **None** in this category ❑ Severe Headaches ❑ Seizures or Convulsions ❑ Stroke ❑ Paralysis ❑ Nerve Damage ❑ Vision Loss ❑ Hearing Loss ❑ Arthritis ❑ T-M Joint Problems (jaw joint) ❑ Chronic Neck Pain or Arthritis

SLEEP APNEA: ***NIGHTTIME:*** ❑ Snore at night ❑ Partner notices pauses in breathing during your sleep ❑ Awaken from sleep with choking sensation ❑ Have frequent arousals from sleep ***DAYTIME:*** ❑ Frequently sleepy or tired during the day despite adequate sleep ❑ Fall asleep during the day in quiet settings (in a car, reading, watching TV) ❑ Use an airway appliance such as a CPAP machine

MISCELLANEOUS: ❑ **None** in this category ❑ HIV ❑ Alcohol Abuse in past ❑ Street Drug Use ❑ Premature Birth

Any life threatening illness, injury or other medical problem not already mentioned? ❑ **None**
Explain: ______________________