HEALTH HISTORY

Please complete the following information to be reviewed by your provider.

Name:_________________________ Birth date: ___________________ Age: ______ Height:_______

Weight:________ Sex: _____

History of problems with anesthesia by yourself or relative? Yes_______ No_______ Describe Below:

____

Lung	Vascular	Systemic	Other
Bronchitis	High Blood Pressure	Anemia	Previous Blood Transfusion
Emphysema	Heart Attack/Chest Pain	Diabetes	Refused Blood Transfusion
Asthma	Heart Murmur	Thyroid Disease	Jehovah's Witness
Hay Fever	Bleeding Tendency	Kidney Disease	Breast Feeding Currently
Sinusitis	Do you take blood thinning	Jaundice, Hepatitis	Loose Teeth, Crowns,
Tuberculosis	medication? (aspirin,	Liver Disease	Dentures, Bridges
Abnormal Chest X-ray	Coumadin)	Cancer	Contact Lenses, Glasses,
Smoking History ___ yrs	Blood Clots	Stomach/Bowel Problems	Legally Blind
___packs per day	Abnormal ECG	Acid Reflux	Hard of Hearing/Hearing Aids
___ yrs quit	Congestive Heart Failure	Convulsions, Epilepsy, Seizures	Caffeine Consumption
A Cold (in the last 2 weeks)	Pacemaker/ AICD	Stroke/ Transient Ischemic Attacks	Mental Illness/Depression
Shortness of Breath		(TIAs)	Neural Abnormality
Home Oxygen ___ Liters		Fainting	(i.e., spina bifdada)
Sleep Apnea/ Snoring/CPAP		Slipped Disc. Sciatica	Motion Sickness
		Broken Bones	Alcohol Use
			# of drinks per day ______
			Recreational Drug Use

Other Significant Health Problems:

____

List of Previous Surgeries, Hospital and Date:

____

Are you currently pregnant: Yes___ NO ___ UNSURE___ If you are of childbearing age, it is recommended that you have a pregnancy test due to the risks of anesthesia.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of the staff responsible for any errors or omissions that I may have made in the completion of this information.

Signature of Patient or Guardian: ___________________________________ Date: _______________

Pre-Operative / Admission Baseline

Time	Height	Weight (Kg)	Temperature	Pulse	Respirations	BP: ☐ Left ☐ Right

SpO2	Notes

Intake: Time & contents of most recent meal	RN Signature	Date

Arrival Time to ASC: _______________

Patient Label