SAN MATEO SURGERY CENTER

PRE-ANESTHESIA EVALUATION YOUR MEDICAL HISTORY

The intention of this questionnaire is to help your anesthesiologist select the proper anesthesia technique for you.

Name (Last, First): **DOB:** **AGE:**

SEX: **FEMALE** ❑ **MALE** ❑

General Health	Excellent ❑	Good ❑	Fair ❑	Poor ❑
Has anyone in your family: had a tendency to bleed excessively?		YES ❑	NO ❑	**Height:**
Had unexplained fevers during anesthesia?		YES ❑	NO ❑	
Had any unusual reactions to anesthesia?		YES ❑	NO ❑	**Weight:**

ONLY CHECK BOXES THAT APPLY TO YOUR MEDICAL HEALTH	YES
Do you smoke?	
Do you drink alcoholic beverages?	
Have you had a blood transfusion?	
Are you pregnant at this time?	

Have you had surgery on the following areas

❑ Jaw ❑ Kidney ❑ Abdomen ❑ Lung

❑ Thyroid ❑ Breast ❑ Heart ❑ Brain

❑ Neck ❑ Other Area not Mentioned

Are you allergic to any medications? **If YES what?**

HAVE YOU EVER HAD..?	YES
Heart Disease? Heart Failure? Heart Attack?	
Heart Murmur? Rheumatic Fever?	
High Blood Pressure?	
Palpitations? (irregular or extra heart beats)	
Chest Pain or Angina?	
Abnormal EKG?	
Stroke?	
Abnormal Shortness of Breath?	
Asthma or Wheezing?	
Emphysema?	
Bronchitis? Pneumonia?	
Tuberculosis?	
Smoker's Cough?	
Hay Fever?	
Hepatitis? Liver Disease?	
Gallbladder Disease?	
Kidney Disease?	
Sickle Cell Anemia?	
Thyroid Disease?	
Diabetes Mellitus?	
Frequent Indigestion? Hiatal Hernia?	
Easy Bruising or Bleeding Excessively?	
Blood Disorders?	
Ulcers? Obstructions?	
Glaucoma?	
Frequent Headaches?	
Nerve Paralysis?	
Fainting Spells?	
Epilepsy? (seizures)	
Back Pain/Back Problems? Arthritis?	
Phlebitis?	
Nervous or Psychiatric Disorder?	
Drug Addiction or Alcoholism?	
Serious Illness During Pregnancy?	
Motion Sickness?	
Illness Not Mentioned?	

DO YOU ANY OF THE FOLLOWING?	YES
Have a false eye?	
Have any teeth loose or chipped?	
Any major physical or congenital defects?	
Have difficulty opening your mouth?	
Have cataracts?	
Wear removable dentures?	
Contact Lenses?	
False eyelashes?	
Have porcelain caps on your teeth?	
Have difficulty w/movement of your head?	

WHAT KIND OF ANESTHESIA HAVE YOU HAD BEFORE?	YES
General (Completely asleep?)	
Saddle/Spinal " Block"/Epidural	
Local or nerve blocks?	
Have you had any unusual reactions?	
Problems or complications with anesthesia?	

MEDICATIONS: Please list names and doses of any medicines you take now or have taken within the last 6 months.

SIGNATURE:

DATE:

Comments: