

PRE- INJECTION EVALUATION YOUR MEDICAL HISTORY

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

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|---|--|---|---|----------------|------------|--|
| Name (Last, First): | | DOB: | | AGE: | | |
| | | SEX: FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> | | | | |
| General Health | Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> | | | | | |
| Has anyone in your family: had a tendency to bleed excessively? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Height: | | |
| Had unexplained fevers during anesthesia? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Weight: | | |
| Had any unusual reactions to anesthesia? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | | | |
| ONLY CHECK BOXES THAT APPLY TO YOUR MEDICAL HEALTH | | YES | Have you had surgery on the following areas | | | |
| Do you smoke? | | | <input type="checkbox"/> Jaw <input type="checkbox"/> Kidney <input type="checkbox"/> Abdomen <input type="checkbox"/> Lung | | | |
| Do you drink alcoholic beverages? | | | <input type="checkbox"/> Thyroid <input type="checkbox"/> Breast <input type="checkbox"/> Heart <input type="checkbox"/> Brain | | | |
| Have you had a blood transfusion? | | | <input type="checkbox"/> Neck <input type="checkbox"/> Other Area not Mentioned | | | |
| Are you pregnant at this time? | | | | | | |
| Are you allergic to any medications? If YES what? | | | | | | |
| HAVE YOU EVER HAD..? | | YES | DO YOU ANY OF THE FOLLOWING? | | YES | |
| Heart Disease? Heart Failure? Heart Attack? | | | Have a false eye? | | | |
| Heart Murmur? Rheumatic Fever? | | | Have any teeth loose or chipped? | | | |
| High Blood Pressure? | | | Any major physical or congenital defects? | | | |
| Palpitations? (irregular or extra heart beats) | | | Have difficulty opening your mouth? | | | |
| Chest Pain or Angina? | | | Have cataracts? | | | |
| Abnormal EKG? | | | Wear removable dentures? | | | |
| Stroke? | | | Contact Lenses? | | | |
| Abnormal Shortness of Breath? | | | False eyelashes? | | | |
| Asthma or Wheezing? | | | Have porcelain caps on your teeth? | | | |
| Emphysema? | | | Have difficulty w/movement of your head? | | | |
| Bronchitis? Pneumonia? | | | WHAT KIND OF ANESTHESIA HAVE YOU HAD BEFORE? | | YES | |
| Tuberculosis? | | | General (Completely asleep?) | | | |
| Smoker's Cough? | | | Saddle/Spinal "Block"/Epidural | | | |
| Hay Fever? | | | Local or nerve blocks? | | | |
| Hepatitis? Liver Disease? | | | Have you had any unusual reactions? | | | |
| Gallbladder Disease? | | | Problems or complications with anesthesia? | | | |
| Kidney Disease? | | | MEDICATIONS: Please list names and doses of any medicines you take now or have taken within the last 6 months. <div style="border: 1px solid black; height: 100px; width: 100%;"></div> | | | |
| 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? | | | SIGNATURE: | | | |
| Drug Addiction or Alcoholism? | | | DATE: | | | |
| Serious Illness During Pregnancy? | | | Comments: | | | |
| Motion Sickness? | | | | | | |
| Illness Not Mentioned? | | | | | | |