PATIENT NAME:_____

CHECK ALL THAT MAY APPLY (SHADED AREAS REQUIRE ANESTHESIA CONSULT)

ANESTHESIA HISTORY	Y	COMMENT
*Life Threatening/Severe reaction to anesthesia		
*History of Difficult Intubation		
*History of Malignant Hyperthermia		
Severe Motion Sickness		
Significant Nausea or Vomitting after anesthesia		
HEART		
*Heart Attack (MI)		
*Coronary artery disease (stents/ angioplasties/ CABG/ angina		
*Heart failure/ CHF		
*Internal Defibrillator (AICD)		
*Pacemaker		
Current Hear murmur/ heart valve problems/ valve replacement		
High Blood Pressure		
Irregular heartbeat		
LUNG/PULMONARY		
Emphysema/ COPD		
Current Oxygen use?		Liters:
Current Bronchitis		
Asthma/ wheezing		
*Sleep apbnea/ snoring		
*CPAP/ Bipap use		
NEUROLOGICAL		
*Stroke		
TIA		
Seizures (in past 5 years)		
*Chronic Pain/ daily narotics		
ENDOCRINE		
Diabetes-use of insulin		☐ Insulin ☐ Pills
Tyroid Disease		
Other		
RHEUMATOLOGY		
Rheumatoid arthritis		
Lupus		
Autoimmune disease		
GASTROINTESTINAL		
GI Bleeding History		
Acid Reflux/ Heartburn		
Hiatal Hernia (stomach)		
RENAL/ HEPATIC		
Kidney Failure/ Dialysis		
Renal Insufficiency		
Urniary Difficulty		
Cirrhosis/ liver disease/ failure		

HEMATOLOGY	Y	COMMENT
*Bleeding disorders/ hemophiliac		
Blood Clots (DVTs/PE)		
*Blood clotting disorder		
*Current blood thinner/ anticoagulants		Last Dose:
Anemia		
Cancer		
Sickle Cell Disease		
INFECTION		
HIV/ AIDS		
Hepatitis B / C		
Tuberculosis		
*Current Active Infection?		
*MRSA history		
PSYCHIATRIC		
Depression		
Anxiety/ nervous breakdown		
SOCIAL HISTORY: DO YOU?		
Smoke		
Chew tobacco		
Drink alcohol daily		
Ever had withdrawals?		
Use of street drugs		
Marijuana		
REVIEW		
Back/ Neck problems		
Fibromyalgia		
Hearing aids		
Contact lens		
Advanced directives		
False/ capped/ loose teeth		
Body piercings		
Implanted hardware/ metal		
Steroid use in last year		Last dose:
Could you be pregnant?		LMP:
FAMILY HISTORY		
Heart attack		
Diabetes		
Cancer		
Blood Clots (DVTs/PE)		
Lung disease/ TB		
Birth defects		
Liver disease		
Kidney disease		

ANESTHESIA CONSULT:

MD Signature_____ Date/Time_____