

ENT & ALLERGY

ASSOCIATES P. S.

Rainier Anesthesia Associates, P.C.

PRE-OPERATIVE MEDICAL HISTORY

Patient Name _____ Age _____ Sex _____ Height _____ Weight _____ BMI _____
 Surgeon _____ Procedure _____ Date of Surgery _____
 Lab _____ CBC _____ Lytes _____ EKG _____ CXR _____ OTHER _____
 Vital Signs _____ Pulse _____ BP _____ O₂ _____

To be completed by all patients (or by their guardians) scheduled for anesthesia. Check answers and fill in the blanks.

<p>Have you had previous surgery? (please list & date) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had difficulty with or do you have concerns about anesthesia? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have a blood relative who had difficulty with anesthesia? (malignant hyperthermia, prolonged weakness, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have difficulty opening your mouth or leaning your head back? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have problems with excessive bleeding, bruising or frequent nose bleeds? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Are you on blood thinners? (Coumadin, Levenox, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had hepatitis, yellow jaundice or any liver problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have kidney problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have neurological problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Seizures, strokes, loss of strength/sensation or muscle disease? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had an ABNORMAL EKG, heart trouble or chest pain with activity? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had a heart procedure? If yes: <input type="checkbox"/> Angioplasty / Stent <input type="checkbox"/> Echo <input type="checkbox"/> Stress Test <input type="checkbox"/> Heart Cath <input type="checkbox"/> CABG <input type="checkbox"/> Valve Surgery <input type="checkbox"/> Pacemaker</p> <p>Do you have a history of high blood pressure? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you required treatment for an elevated serum cholesterol or lipids? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had a parent or sibling with heart problems that began before age 65? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have asthma, bronchitis or emphysema, sleep apnea or problems with significant snoring or have you had an ABNORMAL chest x-ray? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	YES/NO	<p>Do you have ALLERGIES to: medicines, food, tape, soap or latex? If YES, list allergies/reactions <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have frequent heartburn, stomach ulcers, hiatal hernia or reflux? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you currently have a cold/cough? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you get short of breath with daily activity or lying flat? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had steroids in the past three months? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have diabetes? If YES: <input type="checkbox"/> Controlled <input type="checkbox"/> Diet <input type="checkbox"/> Pills <input type="checkbox"/> Insulin</p> <p>Average Blood Sugar Reading: _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you had cancer? Where: _____ <input type="checkbox"/> YES <input type="checkbox"/> NO Date last treated: <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation</p> <p>Do you have: <input type="checkbox"/> Dentures <input type="checkbox"/> Partials <input type="checkbox"/> Caps <input type="checkbox"/> Bridges <input type="checkbox"/> Loose Teeth <input type="checkbox"/> Contacts <input type="checkbox"/> Hearing Aids (R / L) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you drink alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, amount: _____ # years _____</p> <p>Do you smoke/chew tobacco? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, amount: _____ # years _____ Date quit: _____</p> <p>Have you used marijuana, cocaine or other recreational drugs during the past month? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>FEMALES: Could you be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO Last menstrual period: _____</p> <p>PEDIATRICS: Any developmental problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 80%;">Do you take medications? <input type="checkbox"/> Y <input type="checkbox"/> N (please list)</th> <th style="width: 15%;">Last Taken</th> </tr> </thead> <tbody> <tr><td style="background-color: #e0e0e0;"> </td><td> </td><td> </td></tr> <tr><td style="background-color: #e0e0e0;"> </td><td> </td><td> </td></tr> <tr><td style="background-color: #e0e0e0;"> </td><td> </td><td> </td></tr> <tr><td style="background-color: #e0e0e0;"> </td><td> </td><td> </td></tr> <tr><td style="background-color: #e0e0e0;"> </td><td> </td><td> </td></tr> <tr><td style="background-color: #e0e0e0;"> </td><td> </td><td> </td></tr> </tbody> </table>		Do you take medications? <input type="checkbox"/> Y <input type="checkbox"/> N (please list)	Last Taken																			YES/NO
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Signature/Phone: _____ Date: _____

Comments: