



PATIENT LABEL

ANESTHESIA HEALTH HISTORY:

Preferred Name/ Nickname:		Approx HT	Approx WT
ALLERGIES AND MEDICATIONS: see Allergy and Medication Reconciliation form.			
YES	NO	Previous surgeries? Please list with approx year and type of anesthesia if known.	
YES	NO	Have you or anyone in your family had a reaction to anesthesia (nausea, vomiting, high fever, malignant hyperthermia)?	
Please circle any of the following that apply to you: there is more room on the back of this form.			
YES	NO	YES	NO
		Heart Attack/ Angina/ Chest Pain/ Heart Disease/ Mitral Valve Prolapse	Heartburn/ Reflux/ Ulcers/ Hiatal Hernia
		High Blood Pressure/ Fainting	Hepatitis/ Jaundice/ Liver Problems
		Irregular Heart Beat/ Pacemaker/ AICD	Alcohol? How much?
		Asthma (Wheezing)/ Cough/ Tb Breathing Problems	Infectious Diseases
		Sleep apnea, CPAP? Yes No	Dentures/ Chipped or loose teeth/ special dental work
		Smoking? How much? Quit?	Difficulty opening mouth/ TMJ/ stiff neck
		Stroke/ TIA/ Seizures(Epilepsy)last one?	Drug use/ dependency: It is important for your safety to inform the anesthesiologist.
		Headaches/ Neurologic-Nervous Disorder Anxiety/ Depression	Arthritis (where?)
		Diabetes/ Kidney or Bladder Problem/ Thyroid	Other info about you that you would like to share?
		Bleeding / Bruising / Clotting Problem Sickle Cell Disease	

 PATIENT OR LEGAL GUARDIAN'S SIGNATURE RELATIONSHIP DATE

ANESTHESIA PRE-OPERATIVE ASSESSMENT:

Admission Assessment and Pre-op vital signs reviewed.

Airway: _____ Heart: _____

Chest: _____ Other: _____

Labs: _____ EKG: _____

ASA 1 2 3 4 E

Plan: GA MAC SPINAL R L _____ Block (requested by the surgeon for post-op analgesia)

I have discussed the anesthesia plan with the patient/guardian who agrees.

Anesthesiologist Signature

Date

Time