

# Anesthesia Medical History

Patient Name: \_\_\_\_\_ Chart #: \_\_\_\_\_ Start Date: \_\_\_\_\_

Best Phone # during the day: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_ What are you allergic to? \_\_\_\_\_

**Do you now or have you ever had the following:**

<b>CARDIOVASCULAR</b>	<b>YES</b>	<b>NO</b>	<b>NEUROLOGICAL</b>	<b>YES</b>	<b>NO</b>
1. High blood pressure			1. Migraines, chronic headaches		
2. Angina / chest pain /Heart attack			2. Seizure		
3. Irregular heartbeat/ Heart murmur			3. Fainting spells		
4. Congestive heart failure			4. Stroke or mini strokes		
6. Mitral valve prolapse? Do you require antibiotics?			5. Psychiatric condition		
8. Peripheral vascular disease / poor circulation			6. Claustrophobia, panic attacks		
9. Waking up at night short of breath			8. Numbness, tingling, weakness any where in your body? Where?		
10. Restrictions with exercise			9. Other		
11. Other			<b>HEMATOLOGICAL</b>	<b>YES</b>	<b>NO</b>
5. Have you had an EKG? When? Why?			1. Anemia		
<b>PULMONARY</b>	<b>YES</b>	<b>NO</b>	2. Sickle cell disease or trait		
1. Asthma			3. Excessive bleeding problems		
2. Pneumonia or acute bronchitis			4. Blood transfusion		
3. Shortness of breath			5. HIV/AIDS		
4. Sleep apnea. CPAP use?			6. Other		
5. Have you had a chest x-ray? When? Why?			<b>RENAL</b>	<b>YES</b>	<b>NO</b>
6. Use tobacco ___packs/day			1. Kidney Stones		
7. treated for TB			2. Infections		
			3. Other		
<b>ENDOCRINE</b>	<b>YES</b>	<b>NO</b>	<b>DRUG USE</b>	<b>YES</b>	<b>NO</b>
1. Diabetes			1. Alcohol ___/day - ___/week		
2. Thyroid disease			2. Cocaine		
3. Other			3. Marijuana		
<b>MUSCULOSKELETAL</b>	<b>YES</b>	<b>NO</b>	4. Other		
1. Arthritis of neck or jaw			<b>PRESCRIPTIONS/OTC</b>		
2. Muscular dystrophy/sclerosis			1.		
3. Low back pain			2.		
4. Muscle or joint problems			3.		
5. Other			4.		
<b>GASTROINTESTINAL</b>	<b>YES</b>	<b>NO</b>	<b>ANESTHESIA HISTORY</b>	<b>YES</b>	<b>NO</b>
1. Hepatitis/jaundice			1. Nausea or vomiting		
2. Hiatal hernia, frequent heartburn, or indigestion			2. History of serious anesthesia complications for you or your family		
3. Ulcers			3. Motion sickness		
4. Trouble chewing or swallowing			4. Other		

Please answer the questions on page 2

CRNA \_\_\_\_\_ DATE \_\_\_\_\_

# Anesthesia Medical History

Patient Name \_\_\_\_\_

1. What surgical procedures or anesthetics have you had and did you have any anesthesia problems or complications?

Procedure	Anesthesia Type General, sedation, blocks	Problems	Year

2. Do you have any dental work or issues? (circle) **Caps** Crowns **Bridges** Partial plates **Loose**  
Broken **Cracks**

3. Do you have any neck or jaw limitations in movement? **YES NO**

If yes, what limitations? \_\_\_\_\_

4. The Nurse Anesthetist may call you for further information or to clarify something you have written. Do you have questions about anesthesia that you would like to discuss prior to your procedure day?

**YES NO**

5. Please review your anesthesia information sheet the morning prior to your procedure.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

---

**PROCEDURE:** \_\_\_\_\_ **ASA** \_\_\_\_\_ **MP** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_ **NPO** \_\_\_\_\_ **PLAN** \_\_\_\_\_

SaO2		HEART RYTHM			
BP		BREATH SOUNDS			
P		AFFECT			
RR		OLD CHART			
LAB RESULTS	ECG	H&H	NA	K	GLUCOSE

**CRNA SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_