

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:

CARDIOVASCULAR	YES	NO	NEUROLOGICAL	YES	NO
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		
			6. Claustrophobia, panic attacks		
8. Peripheral vascular disease / poor circulation			8. Numbness, tingling, weakness any where in your body? Where?		
9. Waking up at night short of breath			9. Other		
10. Restrictions with exercise					
11. Other			HEMATOLOGICAL	YES	NO
5. Have you had an EKG? When? Why?			1. Anemia		
PULMONARY	YES	NO	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			6. Other		
5. Have you had a chest x-ray? When? Why?			RENAL	YES	NO
6. Use tobacco ___ packs/day			1. Kidney Stones		
7. treated for TB			2. Infections		
			3. Other		
ENDOCRINE	YES	NO	DRUG USE	YES	NO
1. Diabetes			1. Alcohol ___/day - ___/week		
2. Thyroid disease			2. Cocaine		
3. Other			3. Marijuana		
MUSCULOSKELETAL	YES	NO	4. Other		
1. Arthritis of neck or jaw			PRESCRIPTIONS/OTC		
2. Muscular dystrophy/sclerosis			1.		
3. Low back pain			2.		
4. Muscle or joint problems			3.		
5. Other			4.		
GASTROINTESTINAL	YES	NO	ANESTHESIA HISTORY	YES	NO
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 _____

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 <small>General, sedation, blocks</small>	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 _____