ST. BARBARA'S SURGERY CENTER
ANESTHESIA MEDICAL HISTORY

The following set of questions ahs been designed for use by the Anesthesia Department. Please check the appropriate answer for each question. If you do not understand a question, leave it blank.

TO BE FILLED OUT BY PATIENT OR FOR PATIENT BY A RESPONSIBLE PERSON:

Please give us your Height ____________________ and Weight ____________________.

[ ] YES [ ] NO Do you have any loose teeth or dentures?
[ ] YES [ ] NO Do you have any type of physical handicap? What type? ______________
[ ] YES [ ] NO Do you have diabetes?
[ ] YES [ ] NO Do you have high blood pressure?
[ ] YES [ ] NO Have you seen a Cardiologist for any reason?
[ ] YES [ ] NO Have you ever had a stroke?
[ ] YES [ ] NO Have you ever had a hearth attack, angina or chest pain?
[ ] YES [ ] NO Do you have a heart murmur or get palpitations?
[ ] YES [ ] NO Do you have a heart pacemaker?
[ ] YES [ ] NO Have you ever had a seizure or convulsion? (Epilepsy)?
[ ] YES [ ] NO Do you smoke? How many years? ____ # of pks per day? Quit: _______
[ ] YES [ ] NO Do you have asthma, or wheezing spells in your breathing?
[ ] YES [ ] NO Do you get shortness of breath more often then other would?
[ ] YES [ ] NO Do you have emphysema or chronic bronchitis?
[ ] YES [ ] NO Have you ever had tuberculosis (TB) or a positive skin test?
[ ] YES [ ] NO Do you drink alcoholic beverages? Number of drinks per day:___________
[ ] YES [ ] NO Do you use recreational drugs? Last use: ________________
[ ] YES [ ] NO Have you had a cold or flu within the last two weeks?
[ ] YES [ ] NO Do you have stomach ulcers, or frequent heartburn?
[ ] YES [ ] NO Have you ever been told that you have a hiatal hernia?
[ ] YES [ ] NO Have you ever had hepatitis or yellow jaundice?
[ ] YES [ ] NO Do you have any type of kidney or urinary trouble?
[ ] YES [ ] NO Do you have thyroid trouble?
[ ] YES [ ] NO Do you have anemia?
[ ] YES [ ] NO Do you bleed or bruise easily?
[ ] YES [ ] NO Do you have any type of trouble with your back?
[ ] YES [ ] NO Do you have depression or a psychiatric disorder?
[ ] YES [ ] NO Have you or any member of your family ever had any problems with anesthesia?
[ ] YES [ ] NO Have you or any member of your family ever developed a high fever with anesthesia?

Please check any surgeries that you have had in the past:
[ ] Appendectomy [ ] Gall Bladder [ ] Hernia [ ] Hip / Knee Replacement [ ] Stent(s)
[ ] Hysterectomy [ ] Prostate [ ] Other ____
Name of your local medical physician: ____