HEALTH INFORMATION

To help your doctors and nurses provide the best possible care, please fill out this pre-operative health form. Please answer all questions and fill in all blanks. This information will be reviewed with you prior to surgery.

Operation that is planned (in your own words)____

Medications you take regularly____

Medicines to which you are allergic____

Previous operations (include year)____

____

Previous serious illness (include year)____

____

1. Have you ever had a problem with anesthesia or surgery? ☐Yes☐No__________________
2. Has any blood relative had a problem with anesthesia? ☐Yes☐No__________________
3. Have you ever smoked? Number of packs per day? ☐Yes☐No__________________
4. Do you have a cough or cold? ☐Yes☐No__________________
5. Have you ever had asthma? When was the last attack? ☐Yes☐No__________________
6. Have you had bronchitis, pneumonia, or abnormal chest X-ray? ☐Yes☐No__________________
7. Do you get shortness of breath walking up two flights of stairs? ☐Yes☐No__________________
8. Have you any difficulty breathing? ☐Yes☐No__________________
9. Have you ever had high blood pressure? ☐Yes☐No__________________
10. Do you have discomfort or pain in your chest? ☐Yes☐No__________________
11. Have you ever had a heart attack? ☐Yes☐No__________________
12. Have you ever had an irregular heart beat? ☐Yes☐No__________________
13. Have you ever had an abnormal electrocardiogram (ECG)? ☐Yes☐No__________________
14. Have you ever had a heart murmur? ☐Yes☐No__________________
15. Do you drink alcohol? How much? ☐Yes☐No__________________
16. Have you ever had yellow jaundice or hepatitis? ☐Yes☐No__________________
17. Have you had any recent exposure to contagious diseases? ☐Yes☐No__________________
18. Have you ever given yourself intravenous drugs? ☐Yes☐No__________________
19. Have you ever had a stroke? ☐Yes☐No__________________
20. Do you have numbness or weakness in an arm or leg? ☐Yes☐No__________________
21. Have you ever had epilepsy, seizures, or black-out spells? ☐Yes☐No__________________
22. Do you have frequent headaches? ☐Yes☐No__________________
23. Do you have back problems? ☐Yes☐No__________________
24. Have you ever had kidney disease? ☐Yes☐No__________________

25. Do you have diabetes? ☐Yes☐No__________________

26. Do you have a goiter or thyroid disease? ☐Yes☐No__________________

27. Do you have arthritis? ☐Yes☐No__________________

28. Do you have problems opening your mouth/moving your neck? ☐Yes☐No__________________

29. Have you ever had broken bones of face, neck, or back? ☐Yes☐No__________________

30. Have you ever had glaucoma or other eye problems? ☐Yes☐No__________________

31. Have you had an ulcer, hiatal hernia or heartburn? ☐Yes☐No__________________

32. Do you have loose teeth, dentures, or caps on your teeth? ☐Yes☐No__________________

33. Do you have any bleeding tendencies? ☐Yes☐No__________________

34. Could you be pregnant? ☐Yes☐No__________________

35. Any other health problems? ____

List subjects (numbers) you wish to discuss with the Anesthesiologist________________

To the best of my knowledge, the above information is accurate.

Authorized Signature:__________________________

Relationship to Patient:_______________

Date:____/____/_____