

ST. JOHN'S SURGERY CENTER
ANESTHESIA MEDICAL HISTORY

The following set of questions has 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 heart 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 than 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: _____