Height \_\_\_\_\_\_\_\_\_\_ weight\_\_\_\_\_\_\_\_\_ (stated) Previous anesthesia or surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: List on Medication Reconciliation Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (List on Medication Reconciliation Form): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Prescription YES NO Have you had a bad reaction to anesthesia? YES NO
2. Non-prescription YES NO Has any relative had a bad reaction to anesthesia?
3. Street drugs YES NO YES NO

HAVE YOU HAD: Do you:

**Diabetes YES NO** Wear contacts YES NO

Heart problems YES NO Have false or loose teeth YES NO

Chest pain YES NO have dental caps or bridges YES NO

Asthma YES NO Drink alcohol YES NO

Exposure to TB YES NO smoke YES NO

Breathing problems YES NO

Cancer YES NO Are you pregnant? YES NO

Recent cold or infection YES NO

High blood pressure YES NO Patient comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding tendencies YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia/blood problems YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizures, epilepsy, fainting YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paralyses/stroke YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GI/liver problems/ ulcer YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis/jaundice YES NO

Kidney problems YES NO Facility Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immobility of joints/neck/mouth YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Back trouble YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exposure to AIDS YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abnormal chest X-ray YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT STICKER

Abnormal EKG YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Broken bones of the face YES NO

Broken bones of the neck/back YES NO ⬜ This form was reviewed prior to induction

Other medical problems YES NO Dr’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date: \_\_\_\_\_\_time: \_\_\_\_\_\_

Do you have any problems to discuss with the Anesthesia provider who will be giving you anesthetic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you want further risks, hazards, and complications of your anesthetic explained? YES NO

I understand that all anesthetics involve risks and may cause injury and rarely death from both know and unknown causes. I wish to proceed with the procedure and anesthetic.

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_ (or responsible party)

Reviewed with patient on day of surgery. Anesthesia Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_