RAINIER ANESTHESIA ASSOCIATES, P.C.

PRE-OPERATIVE MEDICAL HISTORY

Patient Name_____ Age____ Sex____ Height____ Weight____ BMI____

Surgeon_____ Procedure_____ Date of Surgery_____

Lab____ CBC____ Lytes____ EKG____ CXR____ OTHER_____

Vital Signs Pulse_____ BP_____ O_2_____

To be completed by all patients (or by their guardians) scheduled for anesthesia. Check answers and fill in the blanks.

	YES/NO
• Have you had previous surgery? (please list & date)	❑ ❑
_____	
_____	
_____	
• Have you had difficulty with, or do you have concerns about anethesia?	❑ ❑
_____	
• Do you have a blood relative who had difficulty with anesthesia; (malignant hyperthermia, prolonged weakness, etc.)	❑ ❑
• Do you have difficulty opening your mouth or leaning your head back?	❑ ❑
• Do you have problems with excessive bleeding, bruising or frequent nose bleeds?	❑ ❑
• Are you on blood thinners? (Coumadin, Levenox, etc.)	❑ ❑
• Have you had hepatitis, yellow jaundice or any liver problems?	❑ ❑
• Do you have kidney problems?	❑ ❑
• Do you have neurological problems? Seizures, Strokes, loss of strength/sensation or muscle disease?	❑ ❑
• Have you had an ABNORMAL EKG or heart trouble or chest pain with activity?	❑ ❑
• Have you had a heart procedure? If yes: ❑ Angioplasty / Stent ❑ Echo ❑ Stress Test ❑ Heart Cath ❑ CABG ❑ Valve Surgery ❑ Pacemaker	❑ ❑
• Do you have a history of high blood pressure?	❑ ❑
• Have you required treatment for an elevated serum cholesterol or lipids?	❑ ❑
• Have you had a parent or sibling with heart problems that began before age 65?	❑ ❑
• Do you have asthma, bronchitis or emphysema, sleep apnea or problems with significant snoring or have you had an ABNORMAL Chest X-ray?	❑ ❑

	YES/NO
• Do you have **ALLERGIES** To: **Medicines** or Food, Tape, Soap or **Latex**? If YES list Allergies/Reactions	❑ ❑
_____	
_____	
• Do you have frequent heartburn, stomach ulcers, hiatal hernia or reflux?	❑ ❑
• Do you currently have a cold/cough?	❑ ❑
• Do you get short of breath with daily activity or lying flat?	❑ ❑
• Have you had steroids in the past three months?	❑ ❑
• Do you have Diabetes? If YES: Control ❑ Diet ❑ Pills ❑ Insulin Average Blood Sugar reading _____	❑ ❑
• Have you had cancer? Where: _____ Date last treated: Chemo_____ Radiation_____	❑ ❑
• Do you have: ❑ ↑ ↓ Dentures ❑ ↑ ↓ Partials ❑ Caps ❑ Bridges ❑ Loose teeth ❑ Contacts ❑ Hearing aids (R / L)	❑ ❑
• Do you drink alcohol? If yes, amount: _____ # years _____	❑ ❑
• Do you smoke/chew tobacco? If yes, amt/day:_____ # years _____ Date Quit: _____	❑ ❑
• Have you used marijuana, cocaine, or other recreational drugs during the past month?	❑ ❑
• FEMALES: Could you be pregnant? Last menstrual period: _____	❑ ❑
• PEDIATRICS: Any developmental problems?	❑ ❑

• Do you take medications? ❑ Y ❑ N (please list)	Last taken

Signature/Phone: _____ Date: _____

Comments: _____

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