

APOGEE OUTPATIENT SURGERY CENTER

ANESTHESIA INFORMATION

Name _____ Date _____

Age _____ Height _____ Weight _____ (lbs.) or _____ (kg) _____ BMI _____

Who is your family Doctor? _____

	YES	NO		
Are you allergic to any medicine? List allergies and reactions _____ Latex i.e.: rash, swelling, itching, respiratory problem after contact with rubber products (balloons, rubber gloves, condoms).	_____	_____	<u>COMMENTS:</u>	
Have you had previous surgery with general (sleep) anesthesia? List at right dates and procedure(s).....	_____	_____		
Have you had surgery with regional anesthesia (spinal, arm block, etc.)? List.....	_____	_____		
Have you ever had a problem with any anesthesia? Explain.....	_____	_____		
Has any blood relative had a problem with anesthesia? (e.g.: death, prolonged paralysis, malignant hyperthermia, etc.)?.....	_____	_____		
How many pillows do you sleep with under your head?.....	_____	_____		
Have you ever had a resting electrocardiogram? If yes, with whom and when?.....	_____	_____		Name: _____ Date: _____

LIST MEDICATIONS:

DO YOU HAVE:

A Cardiologist?.....Who? _____			
Cardiac disease (heart attack, heart disease)?.....	_____	_____	
Arterial vascular (blood vessel) disease?.....	_____	_____	
High blood pressure?.....	_____	_____	
Kidney disease?.....	_____	_____	
Convulsive disorder (epilepsy)?.....	_____	_____	
Chronic lung disease (emphysema, tuberculosis, etc.)?.....	_____	_____	
Asthma?.....	_____	_____	
Breathing difficulties with lying flat on your back or climbing a flight of stairs?.....	_____	_____	
Diabetes?	_____	_____	
A bleeding tendency?.....	_____	_____	
Loose teeth, capped teeth, orthodontic or other dental appliance, dentures?.....	_____	_____	
Have you ever had a stroke?.....	_____	_____	
Do you take medicine for your heart or diuretics? List.....	_____	_____	
Do you take any other medicine(s), HERBS, VITAMINS or DIET PILLS? List.....	_____	_____	
When was your last menstrual period?.....	Date	_____	
Are you pregnant?.....	_____	_____	
Do you smoke or have ever smoked? If yes, how much and how often?.....	_____	_____	_____
Do you drink Alcohol? If yes, how much and how often?.....	_____	_____	_____
Any other important health problems or diseases i.e.: hepatitis, immune diseases? List.....	_____	_____	