Adult Health History – Answer each question as completely as possible. Date of surgery_______________ Surgeon_____________

Name____ Age____ Sex____ Height_________ Weight_________ lb_________ kg

Family Doctor's Name, Address & Phone____

Name & Phone of person to contact if case of emergency____

Current medical diagnoses or conditions

Previous operations or surgeries	Anesthesia	Year

Yes No Have you ever had...

- ☐ ☐ TB or any of the following (circle): positive skin test, chest x-ray, or recent exposure
- ☐ ☐ A recent cough of over 3 weeks duration along with coughing up blood, loss of appetite, unexplained weight loss, night sweats, fever/chills, tiring easily
- ☐ ☐ Rheumatic fever or rheumatic heart disease
- ☐ ☐ Murmurs or mitral valve prolapsed
- ☐ ☐ Heart attack; Year__________
- ☐ ☐ Chest pains or angina
- ☐ ☐ Congestive heart failure, other heart disease
- ☐ ☐ Irregular heart beat or palpitations
- ☐ ☐ High blood pressure; How long_
- ☐ ☐ Cold or sore throat within the last 2 weeks
- ☐ ☐ Shortness of breath; on exertion?
- ☐ ☐ Trouble breathing when lying flat
- ☐ ☐ Asthma or emphysema; Do you use an inhaler?____________
- ☐ ☐ Bronchitis
- ☐ ☐ Hepatitis, jaundice or liver disease
- ☐ ☐ Hepatitis-B vaccination
- ☐ ☐ Blood transfusion: When____________________
- ☐ ☐ Testing for HIV
- ☐ ☐ Kidney problems
- ☐ ☐ Muscular weakness or tremors
- ☐ ☐ Stroke or paralysis; Explain____________________
- ☐ ☐ Diabetes; How long____________________
- ☐ ☐ Epilepsy or convulsions; Date of last seizure____________
- ☐ ☐ Bleeding problems or blood clots in legs or lungs
- ☐ ☐ Anemia; excessive bruising
- ☐ ☐ Sickle cell disease
- ☐ ☐ GI bleeding or ulcers
- ☐ ☐ Cancer; Type____________________
- ☐ ☐ Do you smoke; # of cigarettes/packs per day____________
- ☐ ☐ Do you drink alcohol; Drinks per week____________
- ☐ ☐ Have you taken any illicit drugs in the last 2 months
- ☐ ☐ Have you taken cortisone or steroids in the past year
- ☐ ☐ Have you taken tranquilizers or anti-depressants in the last two weeks
- ☐ ☐ Are you allergic to eggs or soybeans
- ☐ ☐ Is there a possibility you are pregnant – date LMP__________
- ☐ ☐ Do you have difficulties opening your mouth, or bending your head back
- ☐ ☐ Have you had a fractured nose or blocked nasal passages
- ☐ ☐ Have you had a nose bleed that required doctor's care

Yes No After Anesthesia have you experienced any of the following:

- ☐ ☐ Severe nausea or vomiting, difficulty waking up, difficulty breathing, high temperature, heart problems, prolonged unconsciousness. Explain:____________________

Do you have (circle all that apply):

- ☐ ☐ Capped teeth, crown, permanent bridge, braces or loose teeth
- ☐ ☐ Dentures, partials or retainers
- ☐ ☐ Contact lenses or glasses
- ☐ ☐ Any implants or prosthesis (i.e. pacemaker, heart valve, artificial hip or joint, breast, hearing aid, lens implant, wigs): Explain:____________________
- ☐ ☐ Need assistance for walking: Explain____________________
- ☐ ☐ Do you have any other impairments/disabilities; Explain_____

SLEEP APNEA SCREENING

- ☐ ☐ Have you ever been diagnosed with sleep apnea? If YES, instruct patient to bring CPAP machine on day of surgery.

IF PATIENT HAS A DIAGNOSIS OF SLEEP APNEA , STOP HERE

- ☐(2) ☐(0) Do you snore most nights?
- ☐(2) ☐(0) Can your snoring be heard through a wall?
- ☐(2) ☐(0) Do you occasionally fall asleep during the day when you are not busy or active?
- ☐(2) ☐(0) Do you occasionally fall asleep when you are driving or stopped at a light?

Have you been told that you stop breathing or gasp during sleep?

☐(5) Frequently ☐(3) Occasionally ☐(0) Never

- ☐(2) ☐(0) is patient being treated for hypertension?

Patient's BMI____________(see BMI calculation grid)

- ☐(5) ☐(0) Is patient's BMI greater than 30?

Total Points______________

To the best of my knowledge this information is correct:

____

Patient/Guardian *Relationship* *Date*

For Hospital Use Only *For Hospital Use Only* *For Hospital Use Only*

*Anesthesia Comments*____________________________________

*Reviewed by*____________________________ *Date*____

*Anesthesiologist*____________________________ *Date*____

*Nursing Comments*____________________________________

Interview ☐ Personal ☐ Phone

*Nurse*____________________________ *Date*____