ENT & ALLERGY ASSOCIATES P.S.

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 anesthesia?	☐	☐
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, heart trouble or chest pain with activity?	☐	☐
Have you had a heart procedure? If yes: ☐ Angioplasty / Stent ☐ Echo ☐ Stress Test ☐ Heart Gath ☐ 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, 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: ☐ Controlled ☐ 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, amount: _____ # 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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