

Have you had or do you have any of the following conditions? (CIRCLE all or any that apply)

Recent Cold or Flu	High Blood Pressure	Jaundice	Hepatitis
Asthma	Heart Attack	Diabetes	Thyroid Disease
Pneumonia	Irregular Heart Beat	Chest Pain	Stroke
Emphysema	Shortness of Breath	Kidney Failure	Ulcer/Acid Reflux
Bronchitis	Hiatal Hernia	Bleeding Tendency	Cancer
Nerve Disease	Muscle Disease	Convulsions	Back Problems
Pacemaker	Defibrillator	Electronic device(s) list: _____	
Alcohol Abuse	Substance Abuse	Sleep Apnea	Use C-PAP at home Settings: _____
Broken bones of your: Additional information/explanations: _____	Face Neck Back	Other Fracture	Physical Limitation / Fall

12_09

Are you taking any herbal supplements? YES / NO (list here): _____

Allergies and type of reactions: (list here):

DO YOU HAVE A LATEX ALLERGY? YES / NO

Have you or any direct relatives had a serious reaction to anesthetic drugs? YES / NO (if yes, explain) _____
LIST ALL PRIOR SURGERIES AND DATES HERE:

Do you wear full or partial dentures? YES / NO	Do you have capped teeth? YES / NO
Do you drink alcohol? YES / NO	HOW MUCH AND HOW OFTEN? _____
Do you smoke or chew tobacco? YES / NO	HOW MUCH AND HOW OFTEN? _____

FEMALES: ARE YOU NOW OR IS THERE A CHANCE THAT YOU ARE PREGNANT? YES / NO _____

Are you aware that there is a risk of danger in EVERY anesthetic given? YES / NO
Please list any issues or questions you would like to discuss with your Anesthesiologist: _____

Patient's Signature
Reviewed by (Anesthesiologist signature): _____

Parent / Guardian Signature and relationship
date: _____