

**Directions to Patients:**

1. Please complete this form for the Anesthesiologist who will review it with you prior to your surgery.
2. Proper completion of this form is important and will help to minimize the risk associated with anesthesia.
3. This form must accompany you to the hospital. Please do not mail it to the hospital.

<p>1. Proposed surgery _____</p> <p>2. Recent hospitalizations (within two years) _____ _____</p> <p>3. Recent surgery _____</p> <p>4. Significant medical problems (check the conditions that apply):  <input type="checkbox"/> High blood pressure  <input type="checkbox"/> Chest pain, angina, any cardiac problems  <input type="checkbox"/> Other heart problems  <input type="checkbox"/> Hepatitis / liver trouble  <input type="checkbox"/> Ulcers, previous abd. surgery, any GI problems  <input type="checkbox"/> Asthma, smoking, shortness of breath, emphysema  <input type="checkbox"/> Kidney problems  <input type="checkbox"/> Diabetes or endocrine problems  <input type="checkbox"/> Bleeding tendency  <input type="checkbox"/> Nervous disorders, strokes, seizures, etc.  <input type="checkbox"/> Skeletal or muscle problems</p> <p>5. Describe your use of:  Tobacco _____  Alcohol _____  Non-prescription / social drugs _____</p> <p>6. Are you currently (please check):  <input type="checkbox"/> Pregnant  <input type="checkbox"/> Suffering from: a cold, sore throat, any infection</p> <p>7. Hours since last food or drink intake _____</p>	<p>8. What medications do you take at home? (Please circle and list the names and dosages of each.):  Blood Pressure Medication _____  Heart Medication _____  Pain or Sleeping Pills _____  Cortisone (steroid) _____  Insulin _____  Anticoagulant (blood thinner) _____  Aspirin _____  Tranquilizers _____  Other Medications _____  Over the Counter Medications _____</p> <p>9. Please list any drug allergies.  Drug _____  Describe type of drug reaction _____</p> <p>10. Previous anesthetics – have you had any unusual reaction to anesthetics?  <input type="checkbox"/> YES or <input type="checkbox"/> NO  Please describe _____</p> <p>Have any relatives had unusual reactions to anesthetics?  <input type="checkbox"/> YES or <input type="checkbox"/> NO  Please describe _____</p> <p>11. Do you have any loose or damaged teeth, implants crowns, bridges, etc?  _____</p> <p>12. Please list any special concerns or questions you may have in regard to your anesthetic.  _____  _____</p>
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**PHYSICIAN ANESTHESIOLOGIST TO COMPLETE THIS PORTION**

I affirm that I have reviewed the above information, pertinent physical findings, and available medical records and provided the above-named patient and/or authorized representative with complete and current information regarding anesthesia plan, including a discussion of the risks, benefits, alternatives, and likely outcomes. She/he consents to this procedure and accepts all risks.

Comments: \_\_\_\_\_

Anesthesia Plan \_\_\_\_\_ ASA \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
Physician Signature \_\_\_\_\_ Airway \_\_\_\_\_