



Dr. Kevin K. Dodd, M.D
Dr. Ari Goldstein, M.D.

Phone : 845-331-8222
Fax: 845-331-7818

ANESTHESIA FORM

Patient Name:

Date of Birth:

Weight:

Height:

Allergies (Examples: Drugs, Food, Latex, Soy, Eggs) and Reaction:

Scheduled Exam: EGD Colonoscopy Flex Sig. ERCP Other: _____

Previous surgeries or procedures: _____

Last time eating/drinking: _____

Personal History of Anesthesia Complications: _____

Family Hx of Anesthesia Complications: _____

Please list all medications and supplements: _____

Aspirin / Anti-inflammatory use: No Yes Dose: _____ Last taken: _____

Do you exercise regularly: No Yes Describe: _____

Would you have difficulty walking 5 blocks or climbing 2 flights of stairs? No Yes

If yes, Why: _____

Do you wake at night with shortness of breath or do you have to sleep sitting upright? No Yes

If yes, Why: _____

Heavy Snoring / Frequent Nighttime Waking? _____ No Yes
 Do you have sleep apnea or use a CPAP? _____ No Yes
 Respiratory Problems (Emphysema, TB, Asthma, Pneumonia, COPD)? _____ No Yes
 Angina / Cardiac Chest Pain / Congestive Heart Failure / Heart Attack? _____ No Yes
 Do you use a blood thinner? Name and time of last dose: _____ No Yes
 Palpitations / Fainting? _____ No Yes
 Do you have high blood pressure? _____ No Yes
 Prosthetic Device / Implants / Heart Valve Defects / Heart Murmur? _____ No Yes
 Neurological Problems? _____ No Yes
 Seizures / Strokes / "Ministrokes" / Blackouts? _____ No Yes
 Leg Cramps / Pain with exertion? _____ No Yes
 Abnormal Bleeding / Bruising Disorder? _____ No Yes
 Anemia? Past Present _____ No Yes
 Gastrointestinal Problems? _____ No Yes
 Kidney / Urinary Problems? _____ No Yes
 Liver Problems (Cirrhosis / Hepatitis)? _____ No Yes
 Diabetes? How long? _____ No Yes
 Thyroid Problems? _____ No Yes
 Arthritis? _____ No Yes
 Muscle / Bone Disorders? _____ No Yes
 Limited Neck Range of Motion or Mouth Opening? _____ No Yes
 Ear, Nose or Throat Problems? _____ No Yes
 Dentures (Full Partial) or Removable Hardware in Mouth? _____ No Yes
 Cancer or Immune System Problems? _____ No Yes
 Psychiatric Problems? _____ No Yes
 Could you be pregnant? _____ No Yes
 Date of Last Menstrual cycle _____
 Is there any other information that you wish to convey to your physician not mentioned above? No Yes

PATIENT SIGNATURE: _____ **DATE:** _____

Above information has been reviewed and any changes were above noted:

Nurse/ Tech Signature: _____ **DATE:** _____

Anesthesiologist Signature: _____ **DATE:** _____

MD Signature: _____ **DATE:** _____

Office use only:

Pregnancy Test results: _____

BSFS results _____

Name of person bringing pt home and contact info: _____