

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

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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: _____