PRE-ANESTHESIA EVALUATION

INSTRUCTIONS TO THE PATIENT- The intention of this questionnaire is to help your anesthetist select the proper anesthetic technique for you.

Name:				Today's Date:
General Health: ¸ Excellent ¸ Good ¸ Fair ¸ Poor	Weight:	Height:	Age:	Sex:

Has anyone in your family:

had a tendency to bleed excessively?	¸ Yes	¸ No
had unexplained fevers during anesthesia?	¸ Yes	¸ No
had any unusual reactions to anesthesia?	¸ Yes	¸ No

YES	NO	YOUR MEDICAL HISTORY
		Do you smoke?
		Do you drink alcoholic beverages?
		Have you had a blood transfusion?
		Are you pregnant at this time?
		Are you allergic to any medications?
		If yes, what?

Have you had surgery on the:

¸ Brain ¸ Neck ¸ Abdomen
¸ Jaw ¸ Kidney ¸ ________________
¸ Heart ¸ Lung ¸ ________________
¸ Thyroid ¸ Breast ¸ ________________

YES	NO	HAVE YOU EVER HAD… ?	YES		HAVE YOU EVER HAD… ?
		Heart Disease? Heart Attack?			Thyroid Disease?
		Heart Murmur? Rheumatic Fever?			Diabetes Mellitus?
		High Blood Pressure?			Frequent Indigestion? Hiatal Hernia?
		Palpitations? (Irregular or extra heart beats)			Ulcers? Obstructions?
		Chest Pain or Angina?			Easy Bruising or Bleeding Excessively?
		Abnormal EKG?			Blood Disorders?
		Stroke?			Glaucoma?
		Abnormal Shortness of Breath?			Frequent Headaches?
		Asthma or Wheezing?			Nerve Paralysis?
		Emphysema?			Fainting Spells?
		Bronchitis? Pneumonia?			Epilepsy? (seizures)
		Tuberculosis?			Back Pain/Back Problems? Arthritis?
		Smoker's Cough?			Phlebitis?
		Hay Fever?			Nervous or Psychiatric Disorder?
		Hepatitis? Liver Disease?			Drug Addiction or Alcoholism?
		Gallbladder Disease?			Serious Illness During Pregnancy?
		Kidney Disease?			Motion Sickness?
		Sickle Cell Anemia?			Other Illness Not Mentioned?
YES	**NO**	**DO YOU?**			**DO YOU?**
		Wear removable dentures?			Have a false eye?
		Contact lenses?			Have any teeth loose or chipped?
		False eyelashes?			Have any major physical or congenital defects?
		Have porcelain caps on your teeth?			Have difficulty opening your mouth?
		Have difficulty w/movement of your head?			Have cataracts?
YES	**NO**	**WHAT KIND OF ANESTHESIA HAVE YOU HAD BEFORE?**			
		Saddle/Spinal "Block"/Epidural			Local or nerve blocks?
		General (completely asleep?)			Have you had any unusual reactions, problems or complications with Anesthesia?
		Pentothal?			

MEDICATIONS:
Please list names and doses of any medications you take now or have taken within the last 6 months.

Fertility Treatment Medications/Supplements (Please indicate your most recent dose):

¸ Lupron ____units/day ¸ Ganirelix _____mcg/day ¸ Menopur _____IU/day ¸ Follistim _____IU/day
¸ Dostinex_____mg/day ¸ Estrace_____mg/day ¸ Saizen _____mg/day ¸ Dexamethasone_____mg/day
¸ Aspirin_____mg/day ¸ Prenatal Vitamins (Name) ________________ ¸ Birth Control Pills (Name) ________________

Non-Fertility Related Medications/Supplements (Please indicate your most recent dose):

¸ ________________ ¸ ________________ ¸ ________________ ¸ ________________
¸ ________________ ¸ ________________ ¸ ________________ ¸ ________________

Patient Signature: