

EMORY JOHNS CREEK HOSPITAL

EMORY HEALTHCARE

Pre-Anesthetic Medical History

PLEASE COMPLETE THIS FORM PRIOR TO YOUR PRE-ANESTHETIC EVALUATION

I AGREE TO HAVE NOTHING BY MOUTH AFTER MIDNIGHT THE NIGHT BEFORE MY SURGERY UNLESS INSTRUCTED TO DO SO.

Height _____ Weight _____ Age _____

- YES ___ NO ___ Is this your first anesthetic?
YES ___ NO ___ Have you ever had problems with anesthesia? Specify _____
YES ___ NO ___ Have members of your family had problems with anesthesia? Specify _____
YES ___ NO ___ If female, date of last menstrual period? _____
YES ___ NO ___ Are you or could you be pregnant?
YES ___ NO ___ Are currently taking any prescription/over-the-counter medications, herbal, and/or dietary supplements;
list medication & dosage _____

DO YOU HAVE OR HAVE YOU HAD:

- YES ___ NO ___ Heart disease (including: heart murmur, pacemaker, catheterization, stents, surgery, mitral valve prolapse)
Specify _____
YES ___ NO ___ Chest pain Do you exercise regularly? YES ___ NO ___ What type _____
YES ___ NO ___ Previous EKG/stress test/echocardiogram Date(s) _____
YES ___ NO ___ High blood Pressure
YES ___ NO ___ Asthma Hospitalizations YES ___ NO ___ how many _____
YES ___ NO ___ Lung disease Specify _____
YES ___ NO ___ Chronic cough
YES ___ NO ___ Shortness of breath
YES ___ NO ___ Sleep apnea CPAP YES ___ NO ___
YES ___ NO ___ Abnormal chest x-ray
YES ___ NO ___ Kidney disease Specify _____ Difficulty voiding YES ___ NO ___
YES ___ NO ___ Liver disease/Hepatitis/Jaundice Specify _____
YES ___ NO ___ Diabetes Year diagnosed _____ Do you take insulin? YES ___ NO ___
YES ___ NO ___ Are you on a special diet Specify _____
YES ___ NO ___ Recent weight loss how much _____
YES ___ NO ___ Epilepsy/Seizures/Stroke/Neurological problems Specify _____
YES ___ NO ___ Autoimmune disorders/Connective tissue disorders/Lupus/Sarcoid Specify _____
YES ___ NO ___ Thyroid or goiter problems Specify _____
YES ___ NO ___ Bowel/colon disease or problems Specify _____
YES ___ NO ___ Frequent heartburn/indigestion, esophageal reflux, hiatal hernia
YES ___ NO ___ Glaucoma YES ___ NO ___ Use eye drops YES ___ NO ___
YES ___ NO ___ Back and/or neck problems Specify _____
YES ___ NO ___ Muscle weakness Specify _____
YES ___ NO ___ Past/present carrier of contagious/infectious disease Specify _____
YES ___ NO ___ Exposure to communicable diseases in the past 3 weeks Specify _____
YES ___ NO ___ Bleeding or clotting abnormalities Specify _____
YES ___ NO ___ History of blood transfusions Specify _____
YES ___ NO ___ Nose surgery
YES ___ NO ___ Broken bones in face, back or neck Specify _____
YES ___ NO ___ Do you or have you ever smoked amount per day _____ how many years _____ year quit _____
Use(d) smokeless tobacco how many years _____ year quit _____
Use(d) recreational drugs type(s) _____ how much _____ how many years _____
use alcohol type(s) _____ how much _____
been treated for substance abuse type(s) _____ when _____
YES ___ NO ___ Steroid use in the past 12 months Specify _____

DO YOU HAVE ANY OF THE FOLLOWING?

Dentures _____ Partial plate _____ Bridgework-permanent _____ Caps/Crowns _____ Chipped/Missing teeth _____

ARE YOU WEARING ANY OF THE FOLLOWING?

Contact lens _____ False eyelashes _____ Wig/hairpiece _____ Hearing aid _____

LIST ADDITIONAL MEDICAL/SURGICAL PROBLEMS:

LIST PREVIOUS SURGERIES:

PATIENT SIGNATURE

PARENT, GUARDIAN, OR NEXT OF KIN
(if patient. unable to sign)

RELATIONSHIP