Lankenau Medical Center
Bryn Mawr Hospital
Paoli Hospital

Main Line Health
Well ahead.™

*OP0200*

Patient I.D.

# ANESTHESIA HEALTH QUESTIONNAIRE

Name:

Date of Birth:

Emergency Contact Name and Phone #:

***Home phone:**

***Cell phone:**

***Work Phone:**

***E-mail Address:**

| **Date of Surgery:** | Height: FT. IN. | Weight: | Language spoken other than English/Communication needs: |
|---|---|---|---|

| **Doctor(s)** | **Phone numbers** | **Date of last visit** |
|---|---|---|
| *Primary Care Physician: | | |
| *Cardiologist: | | |
| Other Specialists: | | |

**Pre-op testing to be completed at _____.**

**Preferred Pharmacy Name _____ Address_____ Phone_____**

**Allergies and Reactions** (Be Specific with Reactions) **No Known Allergies** ☐

Medication Allergies/Reaction:

Food: Metal: Tapes/Bandaids: Latex:

X-ray/Contrast Dye: Iodine Products: Environmental:

| **Name of Medication, Vitamins, Herbal Supplements** **(if you have a complete medication list, please forward with this form)** | **Dose** | **Directions for Use** | **Reason for Medication** | **Date Stopped** |
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**Pneumonia Vaccine** month/yr_____ | **Flu Vaccine** month/yr _____ **Dentures?(Circle):** Full / Partial / Upper / Lower

**Please specify amounts and frequency:**

Cigarettes? Yes ☐ No ☐ Packs per Day # Years **Past Use:** Packs per Day # Years

Alcohol? Yes ☐ No ☐ Recreational Drugs? Yes ☐ No ☐ Specify:

Health History Assessment Continued; please check box if you have had a history of the following:

| Neurological | | Cardiovascular | | Respiratory | |
|---|---|---|---|---|---|
| Stroke with residual | | High blood pressure | | Shortness of breath (# of blocks able to walk) | |
| Stroke without residual | | Low blood pressure | | | |
| Seizures | | Aneurysm | | Pneumonia | |
| Migraines/Headaches | | Heart attack | | COPD/ Emphysema | |
| Swallowing/Speech difficulty | | Heart failure | | Asthma | |
| Head injury/Concussion | | Murmur /leaky valve | | Acute bronchitis | |
| Confusion/Dementia | | Chest pain/ Angina | | Chronic cough | |
| Blackouts/fainting/dizziness | | Irregular pulse/a fib | | Snoring | |
| Numbness/tingling | | Circulation problem | | Sleep Apnea | |
| Head injury | | Phlebitis/blood clots | | CPAP | |
| Memory changes | | Pacemaker/Defibrillator | | TB | |
| Other | | High Cholesterol | | Oxygen – how many liters | |
| | | Cardiovascular intervention/Cardiac Catheterization/Stents | | Seasonal Allergies | |
| | | | | Other | |
| | | Other | | | |
| | | | | | |

| Metabolic | | Musculoskeletal | | Genitourinary | |
|---|---|---|---|---|---|
| Diabetes Type 1 | | Arthritis/DJD | | Burning | |
| Diabetes Type 2 | | Joint Replacement | | Urgency | |
| Hypoglycemia-low blood sugar | | Osteoporosis | | Frequency | |
| Hypothyroid-low thyroid function | | Osteopenia - low bone density | | Blood in urine | |
| Hyperthyroid-overactive thyroid | | Spinal/Back Problems | | Recurrent Urinary Tract Infection | |
| Anemia | | Muscle weakness/spasticity | | Kidney failure/Dialysis | |
| Bleeding disorder | | Fibromyalgia | | Kidney Stones | |
| Obesity | | Quadriplegic | | Prostate problems | |
| Other | | Paraplegic | | Incontinence | |
| | | Other | | Ostomy | |
| | | | | Other | |

| Psychosocial | | Skin | | Cancer/Hematologic/Infections | |
|---|---|---|---|---|---|
| Depression | | Wounds | | History of Cancer/ Type | |
| Panic/Anxiety attacks | | Dry skin | | Immunosuppression | |
| Claustrophobia | | Rash or open areas | | Ever been on isolation? | |
| Physical/Psychological Abuse | | Body piercings/Tattoos | | History of MRSA or Infectious Disease | |
| ADHD | | Petechia/Bruising | | Sexually transmitted disease | |

| Sensory Deficits | | GI | | GYN (females) | |
|---|---|---|---|---|---|
| Vision changes | | Reflux | | LMP/last menstrual period | |
| Hearing deficit | | Ulcer | | Possibility of Pregnancy? | |
| Hearing aids | | Hiatal hernia | | Post-menopausal (not menstruating longer than 1 year | |
| Macular degeneration | | Hepatitis | | | |
| Glaucoma | | Ostomy | | Breast Feeding | |
| Had surgery for Glaucoma | | Change in bowel habits | | Other | |
| Cataracts | | Diverticular disease | | | |
| Had surgery for cataracts | | Crohn's disease/colitis | | | |
| Other | | Constipation | | | |
| | | IBS/ Irritable Bowel Syndrome | | | |
| | | Other | | | |
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| List of All Surgeries | Date Performed |
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**Have you had any problems with anesthesia?**

**Any family history of Malignant Hyperthermia?**

Patient I.D.