ISLAND HEALTH

Patient Name:_____ **Sex:** ☐M ☐F **DOB:**_____ **Age:**_____ **Height/Weight**_____/_____

Date of Surgery:_____ **Surgeon:**_____ **Primary Care Doctor:**_____

Who will accompany you home after your procedure? _____
(You must have a responsible adult to accompany you home after receiving anesthesia)

MEDICAL HISTORY

Have you ever had any of the following: *(Please check all that apply)*

HEART	
☐	Heart attack date_____
☐	Chest pain/angina
☐	High blood pressure
☐	Elevated cholesterol
☐	Irregular heartbeat, type_____
☐	Cardiac stent(s), how many____
☐	Heart murmur
☐	Heart failure
☐	Pacemaker/Defibrillator
☐	Edema/Swelling
☐	Blood clots/DVT
☐	Rheumatic fever
☐	Other_____

RESPIRATORY	
☐	COPD
☐	Emphysema
☐	Asthma
☐	Shortness of breath
☐	Pneumonia
☐	Tuberculosis
☐	Sinus drainage/problems
☐	Sleep apnea CPAP/BiPAP
☐	Lung cancer
☐	Cough
☐	Recent cold? ☐Y ☐N
☐	Other_____

MUSCULOSKELETAL	
☐	Arthritis
☐	Pain location_____
☐	Cane/walker/Crutches _____
☐	Other_____

COVID-19:
Infection: Date_____
Exposure: Date_____

GASTRO-INTESTINAL	
☐	GERD/Heartburn/Reflux
☐	Hepatitis, type_____
☐	Cirrhosis
☐	Gallbladder disease
☐	Difficulty swallowing
☐	Ulcer(s)/Intestinal bleeding
☐	Diverticulosis / Diverticulitis
☐	Bowel obstruction(s)
☐	Barrett's esophagus
☐	Constipation
☐	Nausea, currently? ☐Y ☐N
☐	Other_____

ENDOCRINE	
☐	Diabetes, type_____
☐	Pre-Diabetes
☐	Metabolic Syndrome
☐	Low blood sugar
☐	High blood sugar
☐	Hypothyroidism
☐	Hyperthyroidism
☐	Hashimoto's
☐	Grave's disease
☐	Other_____

GENITOURINARY	
☐	Dialysis
☐	Enlarged prostate
☐	Urinary frequency/Urgency
☐	Urinary retention
☐	Urinary incontinence
☐	Urinary tract infection(s)
☐	Kidney disease
☐	Kidney stones
☐	Females: Pregnant ☐Y ☐N
☐	Females: Last period_____
☐	Other_____

NEUROLOGIC	
☐	Stroke
☐	TIA
☐	Seizures/Epilepsy
☐	Brain tumor
☐	Headaches/Migraines
☐	Neuropathy, where_____
☐	Multiple Sclerosis
☐	Parkinson's
☐	Fibromyalgia
☐	Dementia, type_____
☐	Other_____

MENTAL HEALTH	
☐	BiPolar
☐	Anxiety
☐	Depression
☐	Other_____

OTHER	
☐	Cancer, type _____
☐	Anemia
☐	Bruise easily
☐	Eczema
☐	Psoriasis
☐	Special needs_____
☐	

Do you have any of the following?	
☐	Dentures; Upper / Lower
☐	Loose teeth / Missing
☐	Glasses
☐	Contact lenses
☐	Artificial eye
☐	Hearing aid ☐Right ☐Left
☐	Artificial heart valve

Immunizations:

Flu: Yes, Date:_____ Pneumonia: Prevnar 13: Yes, Date:_____ Pneumovax 23: Yes, Date:_____

COVID-19: ☐ Dose 1 ☐ Dose 2 ☐ Booster

How active are you? ☐ Little ☐ Moderate ☐ Active

Have you ever had anesthesia before? ☐ Yes ☐ No

Have you or a blood relative ever had problems with anesthesia or sedation in the past?

☐ Yes ☐ No If yes, explain: _____

Have you or any blood relative been told they have or may have Malignant Hyperthermia? ☐ Yes ☐ No

Do you want to talk to the anesthesiologist about anything particular? ☐ Yes ☐ No

If yes, please explain: _____

Do you take any blood thinning medications? Please list _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, when? _____ Adverse Reaction? ☐ Yes ☐ No

Smoking History: ☐ Never ☐ Current ☐ Former/Quit, Yr____ ☐ Cigarettes ☐ Pipes ☐ Cigars ☐ Chew

Do you consume alcoholic beverages? ☐ Never ☐ Occasionally ☐ Daily (state usual amount)_____

Have you ever had an alcohol or drug problem? _____

Recreational drug use? _____

(If yes to 2 or more of the following questions, nursing to complete BANG assessment)

Are you being treated for Sleep Apnea? ☐ Yes ☐ No

Do you snore loudly? (louder than talking or loud enough to be heard through closed doors) ☐ Yes ☐ No

Are you often tired during the day? ☐ Yes ☐ No

Do you know if you stop breathing or has anyone witnessed you stop breathing while you sleep? ☐ Yes ☐ No

Do you have high blood pressure or on medication to control high blood pressure? ☐ Yes ☐ No

ALLERGIES/SENSITIVITIES:

NAME	REACTION	NAME	REACTION

CURRENT MEDICATIONS: (include all prescriptions, vitamins, over-the-counter medications). May attach copy of current medication list. ***DO NOT ASSUME THAT WE HAVE A COPY OF YOUR MEDICATION LIST.***

NAME	DOSE	HOW OFTEN	NAME	DOSE	HOW OFTEN

PREVIOUS SURGERIES:

SURGERY	DATE	SURGERY	DATE