Pre-Anesthesia Health History *(to be filled out by parent/patient)*

Today's Date:__________

Patient Name:________________________________ DOB:_____________ Height:_______ Weight______

SURGICAL/ANESTHESIA HISTORY: ☐ None

Surgery: ____ Date: ___________________

Surgery: ____ Date: ___________________

Surgery: ____ Date: ___________________

Is there any Family History of Anesthesia Complications? ☐ Yes ☐ No

If yes, please Explain:

____

____

HOSPITALIZATIONS: ☐ None

Has the patient ever been hospitalized? ☐ Yes ☐ No

If yes, please list reason, dates of hospitalization, and at which hospital they were admitted:

____

____

Has the patient visited the ER in the last 30 days? ☐ Yes ☐ No

If yes, please list reason, date, and at which hospital they were seen:

____

Has the patient seen a specialist for any reason? ☐ Yes ☐ No

If yes, please list what specialty and when they were last seen:

____

MEDICATIONS: ☐ None

Please list **ALL** medications, supplements, inhalers, and medications through a nebulizer (if you need more space, please write on the back):

Medication:	**Reason:**	**Medication:**	**Reason:**

ALLERGIES: ☐ None

Please list any additional food and/or Medication allergies:

☐ Soy ☐ Latex

☐ Eggs ☐ Iodine

☐ Peanuts ☐ Tree nuts

Allergy:_____________________ Reaction:______________________

Allergy:_____________________ Reaction:______________________

Allergy: _____________________ Reaction:______________________

If yes to any of the above, please list reaction: ____

Has the patient been prescribed an epipen? ☐ Yes ☒ No

PATIENT NAME:	DOB:

PULMONARY (LUNGS) ☐ None

☐Asthma/Reactive Airway Disease
☐Recent Cold/Respiratory Infection
☐Bronchitis/Pneumonia (last 6 weeks)
☐Tuberculosis (☐Latent ☐Active)
☐Chronic Cough
☐RSV/Croup
☐COPD/Emphysema
☐Other: ________________________________

CARDIAC (HEART) ☐ None

☐Irregular Heartbeat
☐Heart Murmur
☐Congenital Abnormality
☐Abnormal Heart Tests
☐Chest pain/Palpitations
☐High Blood Pressure
☐Pacemaker
☐Coronary Artery Disease
☐Heart Attack (Date of occurrence:________________)
☐Other: _______________________________

NEUROLOGIC (BRAIN) ☐ None

☐Seizures (date of last seizure :____________)
☐Paralysis/Muscle Weakness
☐Hydrocephalus
☐Fainting/Dizziness
☐Other:_______________________________

ENDOCRINE: ☐ None

☐Diabetes (Date of last A1C:_________ Result:__________)
☐Thyroid Disorder
☐Adrenal Disorder
☐Metabolic Disorder
☐Other:______________________________________

PSYCHOSOCIAL: ☐ None

☐Developmental Delay
☐Autism
☐Intellectual Disability/MR
☐ADD/ADHD
☐Depression/Anxiety
☐Other:______________________________

EAR, NOSE, THROAT ☐None

☐Enlarged Tonsils/Adenoids
☐Sleep Apnea (pauses or gasps in breathing during sleep)
☐Recent Strep or Throat infection
☐Snoring
☐Difficulty Swallowing
☐Other:_______________________________

STOMACH, LIVER, KIDNEYS ☐ None

☐Acid Reflux/GERD
☐Chronic Nausea and/or Vomiting
☐Hiatal Hernia
☐Feeding Tube/PEG tube
☐Hepatitis A, B, or C
☐Chronic Kidney Disease
☐Fatty Liver Disease
☐Cirrhosis of the Liver
☐Other:______________________________________

MUSCULOSKELETAL ☐ None

☐Cerebral Palsy
☐Scoliosis
☐Arthritis
☐Muscular Dystrophy
☐CVA/Stroke/TIA (date of occurrence :___________)
☐Chronic Headaches/Migraines
☐Other:____

BLOOD DISORDERS: ☐ None

☐Anemia
☐Bleeding/Clotting Problems (including family history)
☐Easy Bruising
☐Sickle Cell
☐HIV/AIDS
☐Cancer (Type:___________________)
Date of Diagnosis:____________
☐Other:________________________________

GENETIC DISORDERS: ☐ None

☐Angleman's Syndrome
☐Fragile X
☐Down's Syndrome
☐DiGeorge Syndrome
☐Wolf-Parkinson-White Syndrome
☐Turner's /Klinefelter Syndrome
☐Other: ______________________

Are there any other diagnoses or pertinent medical information you feel we need to be aware of?

If yes, please explain:

____

____

____

____

MEDICAL RECORDS RELEASE DISCLOSURE:

I acknowledge, and hereby consent to the release of all medical records to Advanced Specialty Anesthesia. Medical information will be requested only if pertinent to planning and care associated with requested anesthesia services for mine or my child's upcoming dental or surgical procedure. The following are authorized to disclose information:

Patient Name:____ **DOB:**_______________________

Primary Care Physician:____________________________________ **Phone Number:**__________________________________

Facility Name:____________________________________ **Fax Number:**____________________________________

Specialist Physician:_______________________________________ **Phone Number:**__________________________________

Facility Name:____________________________________ **Fax Number:**____________________________________

Specialist Physician:_______________________________________ **Phone Number:**__________________________________

Facility Name:_____________________________________ **Fax Number:**_____________________________________

Patient/Parent Signature:	Print Name/Relationship to Patient:	Date: