Patient's Name _____ Age____ Sex _____ Date of Surgery_____

Proposed operation _____

Primary care physician name/phone #_____Cardiologist/phone #_____

1. Please list **all previous operations** (and approximate dates)

a.	d.
b.	e.
c.	f.

2. Please list any **Allergies** to medications, latex, food or other (and your reactions to them)

a.	c.
b.	d.

3. Fill out the **TESTS** that you have already completed, list where and when you had them. Please bring all existing reports for your visit. We are NOT suggesting that you require (or need to have) these tests.

a. **ECG** LOCATION: Date:	d. **BLOOD WORK** LOCATION: Date:
b. **STRESS TEST** LOCATION: Date:	e. **SLEEP STUDY** LOCATION: Date:
c. **ECHO/ultrasound of heart** LOCATION: Date:	f. Other: LOCATION: Date:

4. Please list **all Medications** you have taken in the last month (include over-the-counter drugs, inhalers, herbals, dietary supplements and aspirin)

Drug Name	**Drug and how often (am or pm)**	**Drug Name**	**Dose and how often (am or pm)**
a.		f.	
b.		g.	
c.		h.	
d.		i.	
e.		j.	

(Please check YES or NO and circle specific problems)	**YES**	**NO**
4. Have you taken steroids (prednisone or cortisone) in the last year? ……..	☐	☐
5. Have you ever smoked? (Quantify in ___ packs/day for ___ years)……	☐	☐
Do you still smoke? (Quantify in ___ packs/day)……	☐	☐
Do you drink alcohol? (If so, how much?) _____ ……...	☐	☐
Do you use or have you ever used any illegal drugs? (we need to know for your safety)		
6. Can you walk up one flight of stairs without stopping?.....	☐	☐

7. Have you had any problems with your heart?

☐ Chest pain or pressure ☐ Heart attack ☐ Abnormal ECG ☐ Skipped beats

☐ Murmur ☐ Palpitations ☐ Heart failure

8. Do you have high blood pressure?.....	☐	☐

(Please check YES or NO and circle specific problems) **YES** **NO**

9. Do you have diabetes?..... ☐ ☐

10. Have you had any problems with your lungs or your chest? ☐ ☐

☐ Shortness of breath ☐ Emphysema ☐ Bronchitis ☐ Asthma ☐ TB ☐ Abnormal chest x-ray

11. Are you ill now or were you recently ill with a cold, fever, chills, flu or productive cough? ☐ ☐

Describe recent changes _____

12. Have you or anyone in your family had serious bleeding problems? ☐ ☐

☐ Prolonged bleeding from nose ☐ Gums ☐ Tooth extractions ☐ Surgery

13. Have you had any problems with your blood ? ☐ ☐

☐ Anemia ☐ Leukemia ☐ Lymphoma ☐ Sickle cell disease ☐ Blood clots ☐ Transfusions

14. Have you ever had problems with your:

Liver (Cirrhosis; Hepatitis A, B, C; jaundice)?..... ☐ ☐

Kidney (Stones, failure, dialysis)?..... ☐ ☐

Digestive system (frequent heartburn, hiatus hernia, stomach ulcer)?..... ☐ ☐

Back, Neck or Jaws (TMJ, rheumatoid arthritis, Herniation)?..... ☐ ☐

Thyroid gland (under active or overactive)?..... ☐ ☐

15. Have you ever had:

Seizures?..... ☐ ☐

Stroke, facial, leg or arm weakness, difficulty speaking?..... ☐ ☐

Cramping pain in your legs with walking?..... ☐ ☐

Problems with hearing, vision or memory?..... ☐ ☐

16. Have you ever been treated with chemotherapy or radiation therapy? ☐ ☐

17. List indication and dates of treatment: _____

18. Women: Could you be pregnant? Last menstrual period began: _____

18. Have you ever had problems with anesthesia or surgery? ☐ ☐

☐ Severe nausea or vomiting ☐ Malignant hyperthermia (in blood relatives or self)

☐ Breathing difficulties ☐ Problems with placement of a breathing tube

19. Do you have any chipped or loose teeth, dentures, caps, bridgework, braces, problems opening your mouth or swallowing, or choking while eating? ☐ ☐

20. Do your physical abilities limit your daily activities?..... ☐ ☐

21. Do you snore?..... ☐ ☐

22. Do you have sleep apnea?..... ☐ ☐

23. Please list any medical illnesses not noted above:

24. Additional comments or questions for the anesthesiologist?

THANK YOU FOR YOUR HELP!