

LEHIGH ANESTHESIA ASSOCIATES

Patient Information

Patient Name _____ Age _____
 Sex _____ Male _____ Female _____ Height _____ Weight _____
 Date of Surgery _____
 Surgical Procedure to be performed _____
 Known Allergies _____
 Current Medications _____

For Females Only: Date of Last Menstrual Period _____
 Are You Currently Pregnant? _____ YES _____ NO
 Previous Surgeries: _____

Have you ever had general anesthesia? _____ YES _____ NO Any problems? _____ YES _____ NO
 Have you ever had anesthesia sedation? _____ YES _____ NO Any problems? _____ YES _____ NO
 Have you ever had a spinal or epidural? _____ YES _____ NO Any problems? _____ YES _____ NO
 Any family history of anesthesia complications? _____ YES _____ NO

Please check **Yes or No** if you have or have experienced any of the following medical conditions:

<i>AIRWAY</i>	<i>YES</i>	<i>NO</i>		<i>YES</i>	<i>NO</i>
Loose, Chipped or Capped Teeth.			Dental Implants, Dentures, Bridges, Etc.		
Difficulty Opening Mouth Wide.			Difficulty Tilting or Moving Neck.		
Protruding Teeth, Overbite, Recessed Chin.			Previous history of severe sore throat after anesthesia.		

<i>Cardiovascular</i>	<i>YES</i>	<i>NO</i>		<i>YES</i>	<i>NO</i>
Hypertension			Angina		
Previous Myocardial Infarction (Heart Attack).			Congenital/valvular Heart Disease, Mitral Valve Prolapse, Etc.		
Congestive Heart Failure.			Aortic Stenosis, Aortic Regurgitation, Mitral Regurgitation, Etc.		
Arrhythmias (Atrial Fibrillation, Ventricular Tachycardia, Bradycardia, Etc.			History of any blood clots that required anticoagulation. Including, but not limited to heparin or coumadin?		

<i>Respiratory</i>	<i>YES</i>	<i>NO</i>		<i>YES</i>	<i>NO</i>
Cough			Shortness of Breath		
Upper Respiratory Infection			Pneumonia		
Asthma			Bronchitis		
Emphysema (COPD)			Sleep Apnea		
Smoking			Tuberculosis		

Shortness of breath during exertion

<i>Gastrointestinal</i>	<i>YES</i>	<i>NO</i>		<i>YES</i>	<i>NO</i>
Hiatal Hernia			Acid Reflux (Heartburn)		
Bowel Obstruction			Bleeding		
Jaundice			Liver Insufficiency/Failure		
Pancreatitis			Alcohol Use		

Any history of gastric bypass or stapling

<i>Genital Urinary</i>	<i>YES</i>	<i>NO</i>		<i>YES</i>	<i>NO</i>
Electrolyte Abnormalities			Kidney Insufficiency/Failure		
Frequent Urinary Tract Infections.			Were you ever on any type of dialysis		

<i>Neurological</i>	<i>YES</i>	<i>NO</i>		<i>YES</i>	<i>NO</i>
History of Brain Tumor			History of Increased Intracranial Pressure		
Previous Psychiatric History			Neuropathy		
Seizures			Substance Abuse		
Vertigo			Motion Sickness		

<i>Endocrine</i>	<i>YES</i>	<i>NO</i>		<i>YES</i>	<i>NO</i>
Diabetes			Low Blood Sugar		
Adrenal Gland Problems			Over or Under Active Thyroid		
Parathyroid Dysfunction			Obesity		

<i>Musculoskeletal</i>	<i>YES</i>	<i>NO</i>		<i>YES</i>	<i>NO</i>
Abnormalities of the Cervical, Thoracic or Lumbar Spine			History of Scoliosis		
Arthritis			Motor Dysfunction		
Muscular Disorders or Weakness					

<i>Hematological</i>	<i>YES</i>	<i>NO</i>		<i>YES</i>	<i>NO</i>
Bleeding or Clotting Disorders			History of Previous Transfusions		
Anemia			Hepatitis		

When was the last time you were evaluated or saw your family doctor? _____

If you answered yes to any of the above medical problems, please describe history below.

The above information was provided by:

- Patient
- Family Member
- Parent/Guardian

Signature of Patient/Guardian: _____