



PATIENT HISTORY AND CALL SHEET

Patient Assessment of Needs: No Yes: Specify (e.g.: Language, learning, hearing, assistive device, etc.)

AFFIX PATIENT LABEL HERE

Age _____ Height _____ Weight _____

<p>Current medical diagnoses or conditions:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Anticoagulation Screening:</p> <p>Have you taken any blood thinners? (E.G: Coumadin, Heparin, Plavix, Aspirin, NSAIDS, or any others?)</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes: Refer to Medication Sheet Form M</p>												
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">Previous operations or surgeries:</td> <td style="width:30%;">Anesthesia</td> <td style="width:40%;">Year</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	Previous operations or surgeries:	Anesthesia	Year	_____	_____	_____	_____	_____	_____	_____	_____	_____	<p>Allergies (drugs, foods, substances, latex) & describe reaction:</p> <p>_____</p> <p>_____</p> <p>_____</p>
Previous operations or surgeries:	Anesthesia	Year											
_____	_____	_____											
_____	_____	_____											
_____	_____	_____											

PERSONAL HISTORY

HAVE YOU EVER HAD: (Please Circle Yes or No)

1. Fainting Spells Y N
2. Seizures, convulsions, epilepsy Y N
3. Stroke Y N
4. Depression, Mental Illness Y N
5. Hyperthyroid, Hypothyroid Y N
6. Cold or Sore throat/Chronic or frequent coughs within the last 2 weeks Y N
7. Shortness of breath Y N
8. Trouble breathing while laying flat, emphysema, or hayfever Y N
9. Lung Disease(pneumonia, bronchitis, influenza, asthma)..... Y N
10. Obstructive Sleep Apnea Y N
11. Congestive Heart Failure..... Y N
12. Chest Pain or Angina Pectoris Y N
13. Palpitation or fluttering Heart/MVP Y N
14. High Blood Pressure..... Y N
How Long _____
15. Artificial Heart Valves (antibiotics)..... Y N
16. Heart Attack/ Year Y N
17. Date of last EKG _____
18. Pacemaker..... Y N
19. Anemia/Sickle Cell Anemia or trait..... Y N
20. Blood clotting or bleeding problems Y N
21. Diabetes Y N
How Long _____
22. Jaundice or Hepatitis Y N
23. Gastroesophageal Reflux Disease, Hiatal Hernia Y N
24. Bladder, Kidney disease Y N
25. Cancer..... Y N
Type: _____

SOCIAL HISTORY

NEVER OCCASIONALLY DAILY

HAVE YOU TAKEN:

- Street Drugs
- Alcohol
- Do you smoke? : # of cigarettes/packs per day _____

FEMALE ONLY

Date of last menstrual period _____

AFTER ANESTHESIA, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

1. Severe nausea/Vomiting..... Y N
2. High temperature/Malignant Hyperthermia Y N
3. Any other problems following a general anesthetic Y N
4. Has a blood relative ever had problems with anesthesia? Y N
Explain _____

DO YOU HAVE:

1. Any difficulty opening your mouth or moving your head or neck? Y N
2. Dentures, capped teeth, bridges, loose teeth Y N
3. A physical impairment that limits the motion of joints, back, neck or arms..... Y N

To the best of my knowledge this information is correct

Patient signature

Hx Obtained by: _____ Date _____ Time _____
Reviewed by: _____ RN Date _____ Time _____