

ADULT HEALTH HISTORY -- Answer each question as completely as possible.

Name _____ Age _____ Sex _____ Height _____ Weight _____ lb _____ kg

Family Doctor's Name, Address, & Phone _____

Name & Phone of person to contact in case of emergency _____

Current medical diagnoses or conditions
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.....
.....
.....
.....
.....

Previous operations or surgeries	Anesthesia	Year
.....
.....
.....
.....
.....

- YES NO **Have you ever had...**
- TB or any of the following (circle): skin test, chest x-ray, or recent exposure
 - A recent cough of over 3 weeks duration along with coughing up blood, loss of appetite, unexplained weight loss, night sweats, fever/chills, tiring easily
 - Rheumatic fever or rheumatic heart disease
 - Murmurs or mitral valve prolapse
 - Heart attack; Year
 - Chest pains or angina
 - Congestive heart failure, other heart disease
 - Irregular heart beat or palpitations
 - High blood pressure; How long
 - Cold or sore throat within the last 2 weeks
 - Shortness of breath; on exertion?
 - Trouble breathing when lying flat
 - Asthma or emphysema; Do you use an inhaler?
 - Bronchitis
 - Hepatitis, jaundice or liver disease
 - Hepatitis-B vaccination
 - Blood transfusion; When
 - Testing for HIV
 - Kidney problems
 - Muscular weakness or tremors
 - Stroke or paralysis; Explain
 - Diabetes; How long
 - Epilepsy or convulsions; Date of last seizure
 - Bleeding problems or blood clots in legs or lungs
 - Anemia; excessive bruising
 - Sickle cell disease
 - GI bleeding or ulcers.....
 - Cancer; Type.....
 - Do you smoke; # of cigarettes/packs per day.....
 - Do you drink alcohol; Drinks per week.....
 - Have you taken any illicit drugs in the last 2 months
 - Have you taken cortisone or steroids in the past year
 - Have you taken tranquilizers or anti-depressants in the last two weeks
 - Are you allergic to eggs or soybeans
 - Is there a possibility you are pregnant - date LMP.....
 - Do you have difficulties opening your mouth
 - Have you had a fractured nose or blocked nasal passages
 - Have you had a nose bleed that required doctor's care

- YES NO **After anesthesia** have you experienced any of the following:
- Severe nausea or vomiting, difficulty waking up, difficulty breathing, high temperature, heart problems
Explain
 - Has a blood relative ever had problems with anesthesia;
Explain
- Do you have (circle all that apply):**
- Capped teeth, crowns, permanent bridge, braces or loose teeth
 - Dentures, partials or retainers
 - Contact lenses or glasses
 - Any implants or prosthesis (i.e. pacemaker, heart valve, artificial hip or joint, breast, hearing aid, lens implant, wigs);
Explain
 - Need assistance for walking; Explain
 - Do you have any other impairments/disabilities; Explain
- SLEEP APNEA SCREENING**
- Have you ever been diagnosed with sleep apnea? If YES, instruct patient to bring CPAP machine on day of surgery.
IF PATIENT HAS A DIAGNOSIS OF SLEEP APNEA, STOP HERE.
 - (2) (0) Do you snore most nights?
 - (2) (0) Can your snoring be heard through a wall?
 - (2) (0) Do you occasionally fall asleep during the day when you are not busy or active?
 - (2) (0) Do you occasionally fall asleep when you are driving or stopped at a light?
Have you been told that you stop breathing or gasp during sleep?
 (5) Frequently (3) Occasionally (0) Never
 - (2) (0) Is patient being treated for hypertension?
- Patient's BMI _____ (see BMI calculation grid)
- (5) (0) Is patient's BMI greater than 30?
- Total Points _____
- High Risk: ≥ 9 points:** positive sleep apnea screen; flag chart
 - Moderate Risk: 6-8 points:** refer to anesthesia
 - Low Risk: ≤ 5 points:** low probability for sleep apnea

To the best of my knowledge this information is correct. _____
Patient/Guardian
Relationship
Date

Anesthesia Comments _____

Nursing Comments _____

Reviewed By _____ Date _____
 Anesthesiologist _____ Date _____

Interview Personal Phone
 Nurse _____ Date _____