MOUNTAINSTAR
St. Mark's Hospital

Pre-Anesthesia Form

Procedure:	Height:	Stated Weight:	Age:

Allergies to medications (include description of reaction): ☐ No known allergies

Please list any previous surgeries or hospitalizations: ☐ None

Please list all medications that you are currently taking (including aspirin, oxygen, & herbal supplements/vitamins): ☐ None

HEALTH HISTORY

☐ YES ☐ NO DIABETES If yes, circle how controlled: ☐diet ☐oral meds ☐insulin

☐ YES ☐ NO HEART PROBLEMS *(rheumatic fever, murmur, chest pain, heart attack, irregular heartbeat congestive heart failure)*

☐ YES ☐ NO Do you have a pacemaker/AICD?
Serial number: _____
Manufacturer: _____

☐ YES ☐ NO HIGH BLOOD PRESSURE

☐ YES ☐ NO STROKE

☐ YES ☐ NO SEIZURES *(epilepsy, convulsions)*

☐ YES ☐ NO LUNG PROBLEMS *(asthma, chronic cough, pneumonia, shortness of breath)*

☐ YES ☐ NO TUBERCULOSIS / TB

☐ YES ☐ NO Have you been diagnosed with MRSA or VRE?

☐ YES ☐ NO SLEEP APNEA If yes, circle how controlled: ☐home O2 ☐CPAP device

☐ YES ☐ NO LIVER PROBLEMS *(jaundice, hepatitis)*

☐ YES ☐ NO KIDNEY, BLADDER, or PROSTATE PROBLEMS

☐ YES ☐ NO STOMACH PROBLEMS *(ulcers, hiatal hernia, reflux, heartburn)*

☐ YES ☐ NO CANCER

☐ YES ☐ NO Have you had radiation or chemotherapy?

☐ YES ☐ NO BLOOD CLOTS or BLEEDING TENDENCY

☐ YES ☐ NO Do you have any objections to receiving blood products?

☐ YES ☐ NO THYROID PROBLEMS

☐ YES ☐ NO BACK TROUBLE

☐ YES ☐ NO ARTHRITIS

☐ YES ☐ NO MENTAL HEALTH ISSUES / PHOBIAS

☐ YES ☐ NO MUSCLE DISORDERS (MS)

☐ YES ☐ NO SKIN DISORDERS

☐ YES ☐ NO Do you have difficulty moving your head/neck or opening your mouth?

☐ YES ☐ NO OTHER MEDICAL PROBLEMS? *Comment:*
_____

☐ YES ☐ NO ILLNESS, COLD, COUGH or FEVER WITHIN THE LAST WEEK? *Comment:* _____

☐ YES ☐ NO IS THERE POSSIBILITY OF PREGNANCY?

☐ YES ☐ NO HAVE YOU OR A RELATIVE HAD A BAD REACTION TO ANESTHESIA? If yes, circle reaction:
☐nausea ☐vomiting ☐sore throat ☐difficult intubation
☐malignant hyperthermia ☐other (add comment):
_____

☐ YES ☐ NO DO YOU SMOKE?
How much: _____

☐ YES ☐ NO DO YOU DRINK ALCOHOLIC BEVERAGES?
How often: _____

☐ YES ☐ NO DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE OR ADDICTION?

☐ YES ☐ NO Do you use recreational drugs? If yes, list drug:
_____
How often: _____

☐ YES ☐ NO DO YOU WEAR CONTACT LENSES?

DO YOU HAVE ANY OF THE FOLLOWING:

☐ FALSE TEETH ☐ BRIDGES
☐ LOOSE TEETH ☐ CAPPED TEETH
☐ CHIPPED TEETH ☐ RETAINERS

_____ Time: _____ Patient Signature: _____

Patient Label