THE ADVANCED SURGICAL INSTITUTE

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HEALTH INFORMATION

	Circle Yes or No	Comments
1. Have you ever had a problem with anesthesia or surgery?	Yes or No	_____
2. Has any blood relative had a problem with anesthesia?	Yes or No	_____
3. Have you ever smoked? # of packs per day?	Yes or No	_____
4. Do you have a cough or cold?	Yes or No	_____
5. Have you ever had asthma?	Yes or No	_____
6. Have you ever had bronchitis, pneumonia, or abnormal CXR?	Yes or No	_____
7. Do you get short of breath walking up two flights of stairs?	Yes or No	_____
8. Have you had any difficulty breathing?	Yes or No	_____
9. Have you ever had high blood pressure?	Yes or No	_____
10. Do you have discomfort or pain in your chest?	Yes or No	_____
11. Have you ever had a heart attack?	Yes or No	_____
12. Have you ever had an irregular heart beat?	Yes or No	_____
13. Have you ever had an abnormal electrocardiogram (EKG)	Yes or No	_____
14. Have you ever had a heart murmur?	Yes or No	_____
15. Do you drink alcohol? How much?	Yes or No	_____
16. Have you had a yellow jaundice or hepatitis?	Yes or No	_____
17. Have you had any recent exposure to contagious diseases?	Yes or No	_____
18. Have you ever given yourself intravenous drugs?	Yes or No	_____
19. Have you had possible exposure to AIDS?	Yes or No	_____
20. Have you ever had a stroke?	Yes or No	_____
21. Do you have numbness or weakness in an arm or leg?	Yes or No	_____
22. Have you ever had epilepsy, seizure or black-out spells?	Yes or No	_____
23. Do you have frequent headaches?	Yes or No	_____
24. Do you have back problems?	Yes or No	_____
25. Have you ever had a kidney disease?	Yes or No	_____
26. Do you have diabetes?	Yes or No	_____
27. Do you have a goiter or other thyroid disease?	Yes or No	_____
28. Do you have arthritis?	Yes or No	_____
29. Do you have problems opening your mouth/moving your neck?	Yes or No	_____
30. Have you ever had glaucoma or other eye problems?	Yes or No	_____
31. Have you ever had broken bones of the face, neck, or back?	Yes or No	_____
32. Have you ever had an ulcer, hiatal hernia, or heartburn?	Yes or No	_____
33. Do you have loose teeth, dentures, or caps on your teeth?	Yes or No	_____
34. Do you have any bleeding tendencies?	Yes or No	_____
35. Could you be pregnant?	Yes or No	_____
36. Are you allergic to any medication?	Yes or No	_____
37. Are you taking any natural or herbal medications?	Yes or No	_____
38. Any other health problems that we did not list?	Yes or No	_____

List any subjects (by number) you wish to discuss with the anesthesiologist_____

To the best of my knowledge, the above information is accurate

Signature of patient or parent _____ Date:_____