

The Advanced Surgical Institute

19671 Beach Blvd., Suite 321
Huntington Beach, CA 92648

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:** _____

