

Please Answer The Following Questions About Your Health History **AGE** **HEIGHT** **WEIGHT**

1. Please check the box for past problems, or circle the word for present conditions. (Additional space is avail. on the back if necessary)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Angina or Chest Pain (when?_____)                    | <input type="checkbox"/> Anxiety or Depression                                       | <input type="checkbox"/> Neurologic Disease                    |
| <input type="checkbox"/> Heart Attack (when?_____)                            | <input type="checkbox"/> Thyroid Disease   | <input type="checkbox"/> Epilepsy or Seizure                   |
| <input type="checkbox"/> Heart Surgery (when?_____)                           | <input type="checkbox"/> Hiatal hernia, Heartburn, or Reflux                         | <input type="checkbox"/> Stroke or Transient Ischemic Attack   |
| <input type="checkbox"/> Heart Failure (when?_____)                           | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Problems                      | <input type="checkbox"/> Muscle Weakness                       |
| <input type="checkbox"/> Cardiac Workup (when_____)                           | <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Recreational Drug Use                 |
| <input type="checkbox"/> Stress Test (when?_____)                             | <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Fainting                              |
| <input type="checkbox"/> Heart Murmur   | <input type="checkbox"/> Asthma or Wheezing  | <input type="checkbox"/> Dentures or Bridge Work               |
| <input type="checkbox"/> High Blood Pressure                                  | <input type="checkbox"/> Bronchitis <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Loose or Capped Teeth                 |
| <input type="checkbox"/> Rheumatic Fever or Valve Problem                     | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Limited Neck Motion, or TMJ           |
| <input type="checkbox"/> Pacemaker <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Hearing Problem   | <input type="checkbox"/> Lens Implant or Corneal Transplant    |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Claustrophobia  | <input type="checkbox"/> Other Diseases or Problems not listed |
| <input type="checkbox"/> Diabetes   |  | <b>Primary Care Physician</b> _____                            |

2. List any past operations: \_\_\_\_\_

6. Do you smoke? If so, much per day, for how many years? \_\_\_\_\_

If you quit, when did you stop? \_\_\_\_\_

3. Have you or any of your relatives had any problem with Anesthesia or Surgery? \_\_\_\_\_

7. Do you drink alcoholic beverages? If so how much per week? \_\_\_\_\_

4. List all Medications and Supplements (with dosages) you take daily: \_\_\_\_\_

8. For female patients, are you pregnant? \_\_\_\_\_

When was your last menstrual period? \_\_\_\_\_

9. Do you presently have a cold? \_\_\_\_\_

5. List All Drug Allergies: \_\_\_\_\_

10. Is there any other information that you think the Anesthesiologist should know? \_\_\_\_\_

Any history of Latex (rubber) allergy:  yes  no

Signature \_\_\_\_\_ Date \_\_\_\_\_

↓↓↓ PLEASE DO NOT NOT WRITE BELOW THIS LINE ↓↓↓

**Preoperative Chart Review**

Proposed Procedure: \_\_\_\_\_

Pertinent Medical History: \_\_\_\_\_

Labs: N/A Date Drawn: \_\_\_\_\_

HCT/CBC: N/A WNL Pending ABN: \_\_\_\_\_

Chemistry: N/A WNL Pending ABN: \_\_\_\_\_

EKG: N/A WNL NSST'S Pending ABN: \_\_\_\_\_

CXR: N/A WNL Pending ABN: \_\_\_\_\_

Coags: WNL Pending ABN: \_\_\_\_\_

Comments: \_\_\_\_\_

Anesthetic Plan to be determined after evaluation and consultation with the patient on the day of the surgery.

MD/DO

Signature

Date/Time

**Day of Surgery Evaluation:**

Patient identified, examined and chart reviewed

NPO: Confirmed Unknown **Full Stomach**

GER: None Control wRX Occasional Frequent Reflux **Has Symptom Now**

Cardiac History: None Stable As Per H&P Suspicious **Angina**

Family History of MH: None Unknown Suspicious **Positive**

Physical Exam; Airway; MP Class I II III IV

Thyromental Distance: >3fb <3fb No Chin

Neck Extension: Excellent Adequate Reduced Poor

Heart: RRR, no murmur ABN: \_\_\_\_\_

Lungs: Clear, Bilat BS ABN: \_\_\_\_\_

Comments: **Beta-Blocker**  **Taken/Given**  **Needed**  **N/A**

Anesthetic Plan: GA Regional MAC IV Sedation Local

Proposed plan explained, relevant risks reviewed, informed consent

obtained. Patient agrees to proceed. ASA I II III IV V E

MD/DO

Signature

Date/Time

**Post Anesthesia Evaluation**

BP: **Stable** Pain: **Controlled** Comments: \_\_\_\_\_

Pulse: **Stable** Temp: **Stable** \_\_\_\_\_

Resp: **Stable** Oxygen Sats: **Stable** \_\_\_\_\_

Mental Status: **At Baseline** Airway Patency: **Stable** \_\_\_\_\_

Hydration: **Stable** Nausea/Vomiting: **Controlled** \_\_\_\_\_

Discharge To: Home SDS PEDS ICU MWH SH

MD/DO Date/Time: \_\_\_\_\_

Signature



0 R 4 2 2 0



Mary Washington Healthcare

**MWHC Anesthetic Health Questionnaire**

FR-670-MWHC Rev. 4/2016

PATIENT IDENTIFICATION

1 1/4" X 3

**Please Use the Following Space to Provide Additional Information**



0 R 4 2 2 0



**Mary Washington Healthcare**

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**PATIENT IDENTIFICATION**  
1 ¼" X 3