

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 | | Primary Care Physician _____ |

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: _____

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

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

MD/DO

Signature _____ Date/Time _____

Signature _____ Date/Time _____

Post Anesthesia Evaluation

BP: Stable **Pain:** Controlled
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

Comments: _____

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



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1 ¼" X 3