Advanced Specialty Anesthesia
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Pre-Anesthesia Health History

Patient Name:____ **DOB:**____________ **Height:**______ **Weight**______

ALLERGIES:

☐ None
☐ Soy
☐ Eggs
☐ Peanuts
☐ Iodine
☐ Tree nuts
☐ Latex

Please list any additional food and/or Medication allergies:
Allergy: __________________________ Reaction: _______________________
Allergy: __________________________ Reaction: _______________________
Allergy: __________________________ Reaction: _______________________

Has the patient been prescribed an EpiPen? ☐ Yes ☐ No

CURRENT MEDICATIONS:

Please list **ALL** medications, supplements, inhalers, and medications through a nebulizer:

☐ None

Medication:	Reason:	Medication:	Reason:

PREVIOUS SURGERIES & PROCEDURES DONE WITH ANESTHESIA

☐ None

Surgery	Date

HOSPITALIZATIONS:

☐ None

Hospital	Date

OTHER MEDICAL INFORMATION:

- Is there any Family History of Anesthesia Complications? ☐ Yes ☐ No
  - If yes, please Explain: ____
- Has the patient visited the ER in the last 30 days? ☐ Yes ☐ No
  - If yes, please list reason, date, and at which hospital they were seen: _______________________________________
- Primary Care Physician:
- Has patient seen specialty provider?
  - If yes please provide the provider's name, specialty, and date last seen.
    - Provider Name & Specialty: _______________________
    - Date Last Seen: ________________________________

CARDIAC (HEART) ☐ None

☐Irregular Heartbeat
☐Heart Murmur
☐Congenital Abnormality
☐Abnormal Heart Tests
☐Chest pain/Palpitations
☐High Blood Pressure
☐Pacemaker
☐Coronary Artery Disease
☐Heart Attack (Date of occurrence:________________)
☐Last Cardiology Visit:___________
☐ Next Required follow up in ____________ months

STOMACH, LIVER, KIDNEYS ☐ None

☐Acid Reflux/GERD
☐Chronic Nausea and/or Vomiting
☐Hiatal Hernia
☐Feeding Tube/PEG tube
☐Hepatitis A, B, or C
☐Chronic Kidney Disease
☐Fatty Liver Disease
☐Cirrhosis of the Liver
☐Other:____________________________________

NEUROLOGIC (BRAIN) ☐ None
☐Seizures (date of last seizure :____________)
☐Paralysis/Muscle Weakness
☐Hydrocephalus
☐Fainting/Dizziness

MUSCULOSKELETAL ☐ None
☐Cerebral Palsy
☐Scoliosis
☐Arthritis
☐Muscular Dystrophy ☐Chronic Headaches/Migraines
☐CVA/Stroke/TIA (date of occurrence :___________)

ENDOCRINE: ☐ None
☐Diabetes (Date of last A1C:_________ Result:__________)
☐Thyroid Disorder
☐Adrenal Disorder
☐Metabolic Disorder

BLOOD DISORDERS: ☐ None
☐Anemia
☐Bleeding/Clotting Problems (including family history)
☐Easy Bruising
☐Sickle Cell
☐HIV/AIDS
☐Cancer (Type:___________________)
Date of Diagnosis:____________

PSYCHOSOCIAL: ☐ None
☐Developmental Delay
☐Autism
☐Intellectual Disability/MR
☐ADD/ADHD
☐Depression/Anxiety

GENETIC DISORDERS: ☐ None
☐Angleman's Syndrome
☐Fragile X
☐Down's Syndrome
☐DiGeorge Syndrome
☐Wolf-Parkinson-White Syndrome
☐Turner's /Klinefelter Syndrome

PULMONARY (LUNGS) ☐ None
☐Asthma/Reactive Airway Disease
☐Recent Cold/Respiratory Infection
☐Bronchitis/Pneumonia (last 6 weeks)
☐Tuberculosis (☐Latent ☐Active)
☐Chronic Cough
☐RSV/Croup
☐COPD/Emphysema

EAR, NOSE, THROAT ☐None
☐Enlarged Tonsils/Adenoids
☐Sleep Apnea (pauses or gasps in breathing during sleep)
☐Recent Strep or Throat infection
☐Snoring
☐Difficulty Swallowing

Are there any other diagnoses or pertinent medical information you feel we need to be aware of?
If yes, please explain:
____

I understand that withholding any information about my child's or my health could jeopardize his/her safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge. I hereby give permission to Advanced Specialty Anesthesia to discuss and request necessary medical records from any physician/facility named below.

Primary Care Physician: ________________________________

Specialist: _______________________________

Hospital/Other: ____________________________________

Parent/Guardian Signature: __________________________Printed Name: _____________________

Date: ______________ Relationship:___________________________