Advanced Specialty
ANESTHESIA

Pre-Anesthesia Health History *(to be filled out by parent/patient)*

Today's Date:_____

Patient Name:_____ DOB:_____ Height:_____ Weight_____

SURGICAL/ANESTHESIA HISTORY: ☐ None

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Is there any Family History of Anesthesia Complications? ☐ Yes ☐ No

If yes, please Explain:

_____

_____

HOSPITALIZATIONS: ☐ None

Has the patient ever been hospitalized? ☐ Yes ☐ No

If yes, please list reason, dates of hospitalization, and at which hospital they were admitted:

_____

_____

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:

_____

Has the patient seen a specialist for any reason? ☐ Yes ☐ No

If yes, please list what specialty and when they were last seen:

_____

MEDICATIONS: ☐ None

Please list **ALL** medications, supplements, inhalers, and medications through a nebulizer (if you need more space, please write on the back):

Medication:	Reason:	Medication:	Reason:

ALLERGIES: ☐ None Please list any additional food and/or Medication allergies:

☐ Soy ☐ Latex Allergy:_____ Reaction:_____

☐ Eggs ☐ Iodine Allergy:_____ Reaction:_____

☐ Peanuts ☐ Tree nuts Allergy: _____ Reaction:_____

If yes to any of the above, please list reaction: _____

Has the patient been prescribed an epipen? ☐ Yes ☒ No

PATIENT NAME: *DOB:*

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
☐Other: _____

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:_____)
☐Other: _____

NEUROLOGIC (BRAIN) ☐ None

☐Seizures (date of last seizure :_____)
☐Paralysis/Muscle Weakness
☐Hydrocephalus
☐Fainting/Dizziness
☐Other:_____

ENDOCRINE: ☐ None

☐Diabetes (Date of last A1C:_____ Result:_____)
☐Thyroid Disorder
☐Adrenal Disorder
☐Metabolic Disorder
☐Other:_____

PSYCHOSOCIAL: ☐ None

☐Developmental Delay
☐Autism
☐Intellectual Disability/MR
☐ADD/ADHD
☐Depression/Anxiety
☐Other:_____

EAR, NOSE, THROAT ☐None

☐Enlarged Tonsils/Adenoids
☐Sleep Apnea (pauses or gasps in breathing during sleep)
☐Recent Strep or Throat infection
☐Snoring
☐Difficulty Swallowing
☐Other:_____

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:_____

MUSCULOSKELETAL ☐ None

☐Cerebral Palsy
☐Scoliosis
☐Arthritis
☐Muscular Dystrophy
☐CVA/Stroke/TIA (date of occurrence :_____)
☐Chronic Headaches/Migraines
☐Other:_____

BLOOD DISORDERS: ☐ None

☐Anemia
☐Bleeding/Clotting Problems (including family history)
☐Easy Bruising
☐Sickle Cell
☐HIV/AIDS
☐Cancer (Type:_____)
Date of Diagnosis:_____
☐Other:_____

GENETIC DISORDERS: ☐ None

☐Angleman's Syndrome
☐Fragile X
☐Down's Syndrome
☐DiGeorge Syndrome
☐Wolf-Parkinson-White Syndrome
☐Turner's /Klinefelter Syndrome
☐Other: _____

Are there any other diagnoses or pertinent medical information you feel we need to be aware of?

If yes, please explain:

_____
_____
_____
_____

MEDICAL RECORDS RELEASE DISCLOSURE:

I acknowledge, and hereby consent to the release of all medical records to Advanced Specialty Anesthesia. Medical information will be requested only if pertinent to planning and care associated with requested anesthesia services for mine or my child's upcoming dental or surgical procedure. The following are authorized to disclose information:

Patient Name:_____ **DOB:**_____

Primary Care Physician:_____ **Phone Number:**_____

Facility Name:_____ **Fax Number:**_____

Specialist Physician:_____ **Phone Number:**_____

Facility Name:_____ **Fax Number:**_____

Specialist Physician:_____ **Phone Number:**_____

Facility Name:_____ **Fax Number:**_____

Patient/Parent Signature:	Print Name/Relationship to Patient:	Date: