ISLAND HOSPITAL

Patient Name:_____ **Sex:** ☐M ☐F **DOB:**_____ **Age:**_____ **Height/Weight**_____/_____

Date of Surgery:_____ **Surgeon:**_____**Primary Care Doctor:**_____

Who will accompany you home after your procedure? _____
(You must have a responsible adult to accompany you home after receiving anesthesia)

MEDICAL HISTORY

Have you ever had any of the following: *(Please check all that apply)*

HEART	
	Heart attack date_____
	Chest pain/angina
	High blood pressure
	Elevated cholesterol
	Irregular heartbeat_____
	Cardiac stent(s)
	Heart murmur
	Heart failure
	Pacemaker/Defibrillator
	Edema/Swelling
	Blood clots/DVT
	Rheumatic fever
	Other_____

RESPIRATORY	
	COPD
	Emphysema
	Asthma
	Shortness of breath
	Pneumonia
	Tuberculosis
	Sinus drainage/problems
	Sleep apnea CPAP/BiPAP
	Lung cancer
	Cough
	Recent cold? ☐Y ☐N
	Other_____

MUSCULOSKELETAL	
	Arthritis
	Pain location_____
	Cane/walker/Crutches
	Other_____

GASTRO-INTESTINAL	
	GERD/Heartburn/Reflex
	Hepatitis, type_____
	Cirrhosis
	Gallbladder disease
	Difficulty swallowing
	Ulcer(s)/Intestinal bleeding
	Diverticulosis
	Diverticulitis
	Bowel obstruction(s)
	Barrett's esophagus
	Constipation
	Nausea, currently? ☐Y ☐N
	Other_____

ENDOCRINE	
	Diabetes, type_____
	Pre-Diabetes
	Metabolic Syndrome
	Low blood sugar
	High blood sugar
	Hypothyroidism
	Hyperthyroidism
	Hashimoto's
	Grave's disease
	Other_____

GENITOURINARY	
	Dialysis
	Enlarged prostate
	Urinary frequency/Urgency
	Urinary retention
	Urinary incontinence
	Urinary tract infection(s)
	Kidney disease
	Kidney stones
	Females: Pregnant ☐Y ☐N
	Females: Last period_____
	Other_____

NEUROLOGIC	
	Stroke
	TIA
	Seizures/Epilepsy
	Brain tumor
	Headaches/Migraines
	Neuropathy, where_____
	Multiple Sclerosis
	Parkinson's
	Fibromyalgia
	Dementia, type_____
	Other_____

MENTAL HEALTH	
	BiPolar
	Anxiety
	Depression
	Other_____

OTHER	
	Cancer_____
	Anemia
	Bruise easily
	Eczema
	Psoriasis
	Special needs_____

Do you have any of the following?	
	Dentures
	Loose teeth
	Glasses
	Contact lenses
	Artificial eye
	Hearing aid ☐Right ☐Left
	Artificial heart valve

Immunizations:

Flu: Yes, Date:_____ Pneumonia: Prevnar 13: Yes, Date:_____ Pneumovax 23: Yes, Date:_____

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How active are you? ☐ Little ☐ Moderate ☐ Active

Have you ever had anesthesia before? ☐ Yes ☐ No

Have you or a blood relative ever had problems with anesthesia or sedation in the past?

☐ Yes ☐ No If yes, explain: _____

Have you or any blood relative been told they have or may have Malignant Hyperthermia? ☐ Yes ☐ No

Do you want to talk to the anesthesiologist about anything particular? ☐ Yes ☐ No

If yes, please explain:_____

Do you take any blood thinning medications? Please list_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, when?_____ Adverse Reaction? ☐ Yes ☐ No

Smoking History: ☐ Never ☐ Current ☐ Former/Quit, Yr____ ☐ Cigarettes ☐ Pipes ☐ Cigars ☐ Chew

Do you consume alcoholic beverages? ☐ Never ☐ Occasionally ☐ Daily (state usual amount)_____

Have you ever had an alcohol or drug problem?_____

Recreational drug use?_____

(If yes to 2 or more of the following questions, nursing to complete BANG assessment)

Are you being treated for Sleep Apnea? ☐ Yes ☐ No

Do you snore loudly? (louder than talking or loud enough to be heard through closed doors) ☐ Yes ☐ No

Are you often tired during the day? ☐ Yes ☐ No

Do you know if you stop breathing or has anyone witnessed you stop breathing while you sleep? ☐ Yes ☐ No

Do you have high blood pressure or on medication to control high blood pressure? ☐ Yes ☐ No

ALLERGIES/SENSITIVIES:

NAME	REACTION	NAME	REACTION

CURRENT MEDICATIONS: (include all prescriptions, vitamins, over-the-counter medications). May attach copy of current medication list. ***DO NOT ASSUME THAT WE HAVE A COPY OF YOUR MEDICATION LIST.***

NAME	DOSE	HOW OFTEN	NAME	DOSE	HOW OFTEN

PREVIOUS SURGERIES:

SURGERY	DATE	SURGERY	DATE

Patient ID Sticker