PATIENT LABEL

		YES	NO	DON'T KNOW
	1. WHO IS YOUR PRIMARY CARE PHYSICIAN? CARDIOLOGIST?			
CARDIOVASCULAR	2. HAVE YOU EVER HAD TROUBLE WITH YOUR HEART?			
	3. HAVE YOU EVER TAKEN ANY MEDICINE OR PILLS FOR YOUR HEART?			
	4. HAVE YOU EVER HAD HIGH BLOOD PRESSURE REQUIRING MEDICATION?			
	5. DO YOU HAVE PAIN OR PRESSURE IN YOUR CHEST?			
	6. CAN YOU WALK A MILE WITHOUT SHORTNESS OF BREATH/CHEST TIGHTNESS?			
	7. CAN YOU WALK UP TWO FLIGHTS OF STAIRS WITHOUT SHORTNESS OF BREATH/CHEST TIGHTNESS?			
	8. DO YOU GET SHORTNESS OF BREATH/CHEST TIGHTNESS DURING MINIMAL EXERTION?			
RESPIRATORY	9. HAVE YOU EVER TAKEN ANY MEDICINE OR PILLS FOR YOUR BREATHING? WHAT TYPE?			
	10. DO YOU HAVE A CHRONIC COUGH, BRONCHITIS OR ASTHMA? CIRCLE WHICH ONE(S)			
	11. DO YOU SMOKE? HOW MANY PACKS PER DAY?			
	12. HAVE YOU HAD THE FLU OR A COLD IN THE PAST MONTH?			
NEURO-LOGICAL	13. HAVE YOU EVER HAD A STROKE, T.I.A., SEIZURE OR FREQUENT BLACKOUTS?			
	14. DO YOU HAVE NUMBNESS OR SEVERE WEAKNESS IN ANY EXTREMITY?			
GENERAL HEALTH	15. HAVE YOU OR A BLOOD RELATIVE EVER HAD A DISORDER WHERE YOUR BLOOD WOULD NOT CLOT NORMALLY?			
	16. DO YOU HAVE LOOSE, CHIPPED OR FALSE TEETH OR "CROWNS"? CIRCLE WHICH ONE(S)			
	17. HAVE YOU EVER HAD LIVER DISEASE, YELLOW JAUNDICE, KIDNEY DISEASE, GLAUCOMA, DIABETES, PARKINSONS DISEASE, PORPHYRIA, GASTRIC ULCERS, HIATAL HERNIA, OR REFLUX ESOPHAGITIS? CIRCLE WHICH ONE(S)			
	18. HAVE YOU EVER HAD PNEUMONIA, SLEEP APNEA, ARTHRITIS, BACK PAIN, THYROID DISEASE, ANEMIA, ADRENAL GLAND DISEASE OR PERIPHERAL VASCULAR DISEASE? CIRCLE WHICH ONE(S).			
	19. DO YOU DRINK ALCOHOL OR USE RECREATIONAL DRUGS? HOW MUCH?			
	20. DO YOU OR HAVE YOU TAKEN ANY **DIET** MEDICATION OR **HERBAL** MEDICATION WITHIN THE LAST MONTH? PLEASE LIST. WHEN DID YOU LAST TAKE MEDICATION?			
	21. ARE YOU PREGNANT OR IS IT POSSIBLE THAT YOU COULD BE PREGNANT?			
	22. ARE YOU IN ANY WAY PHYSICALLY IMPAIRED?			
	23. WITHIN THE LAST YEAR, HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATION: MEDROL, CORTISONE, DEXAMETHASONE, DECADRON, PREDNISONE, ARISTOCORT, STEROID, HYDROCORTISONE OR ACTH? CIRCLE WHICH ONE(S)			
ALLERGIES	24. TO THE BEST OF YOUR KNOWLEDGE ARE YOU ALLERGIC TO ANYTHING? PLEASE LIST TYPE OF ALLERGY:			
	25. DO YOU HAVE **LATEX** ALLERGY?			
	26. HAVE YOU OR A BLOOD RELATIVE EVER HAD A REACTION TO A LOCAL OR GENERAL ANESTHETIC?			

27. YOUR WEIGHT _____ LBS HEIGHT _____

28. HAVE YOU HAD ANY SERIOUS ILLNESSES DURING YOUR LIFE? PLEASE LIST WITH THE DATES _____

29. PLEASE LIST BELOW ALL DRUGS OR MEDICINES YOU HAVE BEEN TAKING REGULARLY. IF YOU DO NOT KNOW THE NAME OF A MEDICINE TELL THE REASON FOR TAKING IT.

30. PLEASE LIST BELOW THE OPERATIONS YOU HAVE HAD DURING YOUR LIFE WITH DATES (YEAR IS SUFFICIENT). PLEASE INCLUDE MINOR PROCEDURES SUCH AS CYSTOSCOPIES, SETTING OF BONE FRACTURES AND ORAL SURGERY IF YOU WERE PUT TO SLEEP FOR THESE.

Signature (Patient, or Guardian, if minor)

Reviewed by: (Department of Anesthesiology)

Reviewer R.N.

Date