**A picture containing drawing

Description automatically generated This form MUST BE completed in FULL**

**IF you are planning to have Surgery**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name: | | |  | | | | | Phone# | |  | | | | | | |
| Height: |  | | | | Weight: | |  | Birth Date: | | |  | | | Age: | |  |
|  | | | | | | | | | | | | | **Yes** | | | **No** |
| Are you pregnant? | | | | | | | | | | | | |  | | |  |
| Do you have a severe Latex Allergy (Anaphylaxis)? | | | | | | | | | | | | |  | | |  |
| Have you ever had a seizure? When? | | | | | | | | | | | | |  | | |  |
| Do you have a cardiac history? | | | | | | | | | | | | |  | | |  |
| Do you have unstable angina? | | | | | | | | | | | | |  | | |  |
| Do you have uncompensated CHF (Congestive Heart Failure)? | | | | | | | | | | | | |  | | |  |
| If so, have you ever been hospitalized for your CHF? | | | | | | | | | | | | |  | | |  |
| Do you take a diuretic “water pill”? | | | | | | | | | | | | |  | | |  |
| Do you have heart stents? | | | | | | | | | | | | |  | | |  |
| Are you on any anti-clotting “blood thinner” medications? | | | | | | | | | | | | |  | | |  |
| Do you have high blood pressure? | | | | | | | | | | | | |  | | |  |
| Have you had bypass surgery? | | | | | | | | | | | | |  | | |  |
| Have you had a heart valve replacement? | | | | | | | | | | | | |  | | |  |
| Do you have a pacemaker or defibrillator? | | | | | | | | | | | | |  | | |  |
| Are you under the care of a cardiologist? | | | | | | | | | | | | |  | | |  |
| Do you have history of a difficult airway? | | | | | | | | | | | | |  | | |  |
| Do you have history of malignant hyperthermia? | | | | | | | | | | | | |  | | |  |
| Do you have history of anesthesia complications? | | | | | | | | | | | | |  | | |  |
| Do you have sleep apnea? | | | | | | | | | | | | |  | | |  |
| Do you use a CPAP? | | | | | | | | | | | | |  | | |  |
| Do you have history of emphysema, COPD or other Breathing Diagnosis? | | | | | | | | | | | | |  | | |  |
| Do you have history of asthma? | | | | | | | | | | | | |  | | |  |
| Do you use an inhaler? | | | | | | | | | | | | |  | | |  |
| Do you use tobacco? | | | | | | | | | | | | |  | | |  |
| Do you have diabetes? | | | | | | | | | | | | |  | | |  |
| Are you on dialysis? | | | | | | | | | | | | |  | | |  |
| Do you have history of CRF (Chronic Renal Failure)? | | | | | | | | | | | | |  | | |  |
| Do you have history of CRI (Chronic Renal Insufficiency)? | | | | | | | | | | | | |  | | |  |
| Do you have liver disease? | | | | | | | | | | | | |  | | |  |
| Do you take an appetite suppressant? | | | | | | | | | | | | |  | | |  |
| **Contact Information** | | | | | | | | | | | | | | | | |
| Primary Care Physician Name: | | | | | | |  | | | | | Phone #: |  | | | |
| Cardiologist Name: | | | | | |  | | | | | | Phone #: |  | | | |
| Other Physician: | | | |  | | | | | | | | Phone #: |  | | | |
| Signature: | |  | | | | | | | Date Form was Completed: | | | | | |  | |