** 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: |  |