Please Answer The Following Questions About Your Health History **AGE_____HEIGHT_____WEIGHT**

1. Please check the box for past problems, or circle the word for present conditions. (Additional space is avail. on the back if necessary)

- □ Angina or Chest Pain (when?_____)
- □ Heart Attack (when?_____)
- □ Heart Surgery (when?_____)
- □ Heart Failure (when?_____)
- □ Heart Murmur
- □ High Blood Pressure
- □ Pacemaker
- □ Rheumatic Fever or Valve Problem
- □ Anemia □ Bleeding Problems
- □ Diabetes
- □ Anxiety or Depression
- □ Thyroid Disease
- □ Hiatal hernia, Heartburn, or Reflux
- □ Hepatitis, Jaundice, or Liver Problems
- □ Kidney Disease
- □ COPD or Emphysema
- □ Tuberculosis
- □ Asthma or Wheezing
- □ Bronchitis □ Obstructive Sleep Apnea
- □ Shortness of Breath
- □ Hearing Problem
- □ Claustrophia
- □ Neurologic Disease
- □ Epilepsy or Seizure
- □ Stroke or Transient Ischemic Attack
- □ Muscle Weakness
- □ Recreational Drug Use
- □ Fainting
- □ Dentures or Bridge Work
- □ Loose or Capped Teeth
- □ Limited Neck Motion, or TMJ
- □ Lens Implant or Corneal Transplant
- □ Other Diseases or Problems not listed

2. List any past operations: _____

3. Have you or any of your relatives had any problem with Anesthesia or Surgery?_____

4. List all the Medications (with drug dosages) you take daily: _____

5. List All Drug Allergies: _____

Any history of Latex (rubber) allergy: □ yes □ no

6. Do you smoke? If so, much per day, for how many years?

If you quit, when did you stop?_____

7. Do you drink alcoholic beverages? If so how much per week?

8. For female patients, are you pregnant? _____
When was your last menstrual period? _____

9. Do you presently have a cold? _____

10. Is there any other information that you think the Anesthesiologist should know?_____

Signature_____ Date _____

↓↓↓ PLEASE DO NOT WRITE BELOW THIS LINE ↓↓↓

Preoperative Chart Review

Proposed Procedure: _____
Pertinent Medical History: _____

Labs: N/A Date Drawn: _____
HCT/CBC: N/A WNL Pending ABN: _____
Chemistry: N/A WNL Pending ABN: _____
EKG: N/A WNL NSST'S Pending ABN: _____
CXR: N/A WNL Pending ABN: _____
Other Tests:_____
Comments: _____

Anesthetic Plan to be determined after evaluation and consultation with the patient on the day of the surgery.

MD/DO
Signature Date/Time

Day of Surgery Evaluation:

Patient identified, examined and chart reviewed
NPO: Confirmed Unknown **Full Stomach**
GER: None Occasional Frequent Reflux **Has Symptoms Now**
Cardiac History: None Atypical Chest Pain Suspicious **Angina**
Family History of MH: None Unknown Suspicious **Positive**
Physical Exam; Airway; MP Class I II III IV
Thyromental Distance: >3fb <3fb No Chin
Neck Extension: Excellent Adequate Reduced Poor
Heart: RRR, no murmur ABN: _____
Lungs: Clear, Bilat BS ABN: _____
Comments: _____

Anesthetic Plan: GA Regional MAC IV Sedation Local
Proposed plan explained, relevant risks reviewed, informed consent obtained. Patient agrees to proceed. ASA I II III IV V E

MD/DO
Signature Date/Time

Recovery Room and Discharge Evaluation

Blood Pressure _____ Stable
Pulse _____ Stable
Respiration _____ Adequate
Discharge To: Home SDS PEDS ICU MWH SH
Time of Discharge Evaluation: _____

Remarkable Events in the Recovery Room: _____

MD/DO
Signature Date/Time

0R4220

Mary Washington Healthcare

MWHC Anesthetic Health Questionnaire
FR-670-MWHC Rev. 1/2010

PATIENT IDENTIFICATION
1 ¼" X 3

Please Use the Following Space to Provide Additional Information

PATIENT IDENTIFICATION
1 ¼" X 3