MultiCare
Cascade Surgical Center

RAINIER ANESTHESIA ASSOCIATES
Preoperative Medical History

Please answer all questions completely.

Patient Name: _____ DOB: _____ Height: _____ Weight: _____
Best daytime phone #: _____ May we leave a message at this #? ☐ YES ☐ No
Do you require an interpreter? ☐ YES ☐ No. Language required: _____
PCP: _____ Surgeon: _____
Procedure: _____ Date of Surgery: _____

Have you had previous surgery (if yes, please list and date)? ☐ Yes ☐ No

_____
_____
_____
_____

☐ YES ☐ No Difficulty/concerns with previous anesthetic. _____
☐ YES ☐ No Blood relative (parent, sibling) who had a serious reaction to anesthesia that involved a fever, seizures or hospital admission. Type of reaction: _____

Patient Medical History:

☐ YES ☐ No High blood pressure
☐ YES ☐ No High cholesterol or lipids
☐ YES ☐ No Kidney disease _____
☐ YES ☐ No Heartburn/stomach ulcers/reflux
☐ YES ☐ No Hiatal hernia
☐ YES ☐ No CVA/TIA/stroke
☐ YES ☐ No Neuromuscular disease
☐ YES ☐ No Previous DVT/PE
☐ YES ☐ No Blood clotting disorder _____
☐ YES ☐ No Hepatitis/jaundice/liver disease
☐ YES ☐ No Excessive bleeding/bruising/nose bleeds
☐ YES ☐ No Asthma/bronchitis/COPD
☐ YES ☐ No Sleep apnea. CPAP? ☐ YES ☐ No
☐ YES ☐ No Previous heart attack
☐ YES ☐ No Chest pain with activity
☐ YES ☐ No Short of breath with activity/lying flat
☐ YES ☐ No Heart problems/abnormal EKG
☐ YES ☐ No Abnormal chest x-ray
☐ YES ☐ No Diabetes. If yes, controlled with ☐ diet, ☐ pills, ☐ insulin. Average blood sugar reading: _____
☐ YES ☐ No Cancer. What type? _____
Date last treated with: Chemo _____ Radiation _____
☐ YES ☐ No Parent or sibling with heart problems that began before age 65. _____

Cardiac testing/procedures: ☐ Stress test ☐ Echo ☐ Angioplasty/stent ☐ Heart cath ☐ Valve surgery ☐ CABG/heart bypass
Do you have: ☐ Upper/lower dentures ☐ Upper/lower partials ☐ Caps ☐ Loose teeth ☐ Bridges
☐ Contacts ☐ Hearing aids (☐ Right ☐ Left)

Social History:

☐ YES ☐ No Alcohol use. If yes, # of drinks/week: _____
☐ YES ☐ No Smoker/chew tobacco. If yes, amount/day: _____ # years: _____ Date quit: _____
☐ YES ☐ No Recreational drug use (marijuana, cocaine, crystal meth, etc). What/last used? _____

Females: Could you be pregnant? ☐ YES ☐ No Last menstrual period: _____

Medications: ☐ **None**

Drug	Dosage	Drug	Dosage

☐ YES ☐ No Do you take blood thinners? (Coumadin, Xarelto, Lovenox, etc) _____
☐ YES ☐ No Have you been on steroids (oral or intravenous) within the last 3 months? _____

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Allergies: ☐ None

☐ Latex ☐ Iodine ☐ Shellfish ☐ Adhesives

Medication/Substance	Reaction

Please attach a list if you need more space.

Patient Information:

Would you like the anesthesiologist to contact you by phone prior to the procedure? ☐ YES ☐ No

If so, please provide the best phone number below:

Contact number: _____ Best time of day to contact: _____

The information I have provided above is accurate and complete regarding current and past illnesses, medications (including herbal supplements), and other matters pertaining to the patient's health and complete medical history.

_____ _____

Signature Date