RAINIER ANESTHESIA ASSOCIATES, P.C.

PRE-OPERATIVE MEDICAL HISTORY

Patient name ______________ Date of birth ________ Ht ______ Wt ______ BMI ____
Parent or legal guardian name ______________ Relationship ______________
Surgeon ______________ Procedure ______________ Date ________

To be completed by all patients (or by their guardians) scheduled for anesthesia. Check answers and fill in the blanks.

YES/NO

- Have you had previous surgeries? (please list & date) ❑ ❑
- Have you had difficulty with, or do you have concerns about anesthesia? Explain: ________ ❑ ❑
- Do you have a blood relative who had difficulty with anesthesia (malignant hyperthermia, prolonged weakness, etc.) ❑ ❑
- Do you have difficulty opening your mouth or leaning your head back? ❑ ❑
- Do you have problems with excess bleeding/bruising or frequent nose bleeds? ❑ ❑
- Have you needed a blood transfusion in the last year? ❑ ❑
- Are you on blood thinners? (Coumadin, Lovenox, etc.) ❑ ❑
- Have you had hepatitis, yellow jaundice or any liver problems? ❑ ❑
- Do you have kidney problems or have you been hospitalized in the last year with it? ❑ ❑
- Do you have neurological problems? Seizures, strokes, loss of strength/sensation or muscle disease? ❑ ❑
- Can you climb two flights of stairs? Y / N Do you get chest pain or short of breath during the activity? ❑ ❑
- Have you had an ABNORMAL EKG or chest X-ray, or heart issues? Explain: ________ ❑ ❑
- Have you had a heart procedure? If yes: ❑ ❑
  ❑ Angioplasty / Stent ❑ Echo ❑ Stress Test
  ❑ Heart Cath ❑ CABG ❑ Valve Surgery ❑ Ablation
  ❑ Pacemaker / Defibrillator ❑ Other ________
- Do you have a history of high blood pressure? ❑ ❑
- Have you required treatment for an elevated serum cholesterol or lipids? ❑ ❑
- Have you had a parent or sibling with heart problems that began before age 65? ❑ ❑
- Do you have asthma, bronchitis or emphysema, sleep apnea or problems with significant snoring? ❑ ❑
  ❑ Check here if you use **oxygen** at home or with activity.

YES/NO

- Do you have **ALLERGIES** to: **Medicines** or Food, Tape, Soap or **Latex**? If YES list Allergies/Reactions ❑ ❑
- Do you have frequent heartburn, stomach ulcers, hiatal hernia or reflux? ❑ ❑
- Do you currently have a cold/cough? ❑ ❑
- Have you had steroids in the past three months? ❑ ❑
- Do you have Diabetes? ❑ ❑
  If YES, controlled with: ❑ Diet ❑ Pills ❑ Insulin / other injection
  Average Blood Sugar reading: ________
- Have you had cancer? ❑ ❑
  Where: ________ Date last treated: ________
  Chemo: ________ Radiation: ________
- Do you have: ❑ (↑ ↓) Dentures ❑ (↑ ↓) Partials ❑ ❑
  ❑ Caps ❑ Bridges ❑ Loose teeth
  ❑ Contacts ❑ Hearing aids (R / L)
- Do you drink alcohol? ❑ ❑
  If YES, amount/wk: ________ # years: ________
- Do you smoke/chew tobacco? ❑ ❑
  If YES, amt/day: ________ # years: ________
  Date Quit: ________
- Have you used marijuana, cocaine, or other recreational drugs during the past month? ❑ ❑
- FEMALES: Could you be pregnant? ❑ ❑
  Last menstrual period: ________
- PEDIATRICS: Any congenital or developmental problems, or complications at birth? ❑ ❑
- MEDICATIONS: Do you take medication for weight loss? ❑ ❑
  Examples: phentermine (Adipex, Lomaira), fenfluramine, semaglutide (Ozempic, Wegovy, Rybelsus), dulaglutide (Trulicity), liraglutide (Saxenda, Victoza), lixisenatide (Adlyxin) or exenatide (Bydureon BCise, Byetta).
- List ALL medications (continue on back if needed)

List ALL medications	Last taken

Signature/Phone: ______________ Date: ________

Comments: ______________

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