Lankenau Medical Center
Bryn Mawr Hospital
Paoli Hospital
Riddle Hospital

Main Line Health®
Well ahead.®

OP0200

Patient ID

ANESTHESIA HEALTH QUESTIONNAIRE

Name:

Date of birth:

Emergency contact name and phone:

Home phone:

Cell phone:

Work phone:

Email address:

Date of surgery:	Height: FT. IN.	Weight:	Language spoken other than English/communication needs:

Doctor(s)	**Phone numbers**	**Date of last visit**
Primary care physician:		
Cardiologist:		
Other specialists:		

Pre-op testing to be completed at:

Preferred pharmacy name: **Address:** **Phone:**

Allergies and reactions (be specific with reactions) **No known allergies**

Medication allergies/reaction:

Food: Metal: Tapes/bandaids: Latex:

X-ray/contrast dye: Iodine products: Environmental:

Name of medication, vitamins, herbal supplements (if you have a complete medication list, please forward with this form)	**Dose**	**Directions for use**	**Reason for medication**	**Date stopped**

Pneumonia vaccine month/year	**Flu vaccine** month/year	**Dentures (circle)** full/partial/upper/lower

Please specify amounts and frequency:

Cigarettes Yes ( ) No ( ) Packs per day #Years **Past use:** Packs per day #Years

Alcohol Yes ( ) No ( ) Recreational drugs Yes ( ) No ( ) Specify:

Health history assessment continued; please check box if you have had a history of the following:

Neurological		Cardiovascular		Respiratory	
Stroke with residual		High blood pressure		Shortness of breath (# of blocks able to walk)	
Stroke without residual		Low blood pressure			
Seizures		Aneurysm		Pneumonia	
Migraines/headaches		Heart attack		COPD/emphysema	
Swallowing/speech difficulty		Heart failure		Asthma	
Head injury/concussion		Murmur/leaky valve		Acute bronchitis	
Confusion/dementia		Chest pain/AFib		Chronic cough	
Blackouts/fainting/dizziness		Irregular pulse/AFib		Snoring	
Numbness/tingling		Circulation problem		Sleep apnea	
Head injury		Phlebitis/blood clots		CPAP	
Memory changes		Pacemaker/defibrillator		TB	
Other		High cholesterol		Oxygen–how many liters	
		Cardiovascular intervention/cardiac catheterization/stents		Seasonal allergies	
				Other	
		Other			

Metabolic		Musculoskeletal		Genitourinary	
Diabetes type 1		Arthritis/DJD		Burning	
Diabetes type 2		Joint replacement		Urgency	
Hypoglycemia-low blood sugar		Osteoporosis		Frequency	
Hypothyroid-low thyroid function		Osteopenia–low bone density		Blood in urine	
Hyperthyroid-overactive thyroid		Spinal/back problems		Recurrent urinary tract infection	
Anemia		Muscle weakness/spasticity		Kidney failure/dialysis	
Bleeding disorder		Fibromyalgia		Kidney stones	
Obesity		Quadriplegic		Prostate problems	
Other		Paraplegic		Incontinence	
		Other		Ostomy	
				Other	

Psychosocial		Skin		Cancer/hematologic/infections	
Depression		Wounds		History of cancer/type	
Panic/anxiety attacks		Dry skin		Immunosuppression	
Claustrophobia		Rash or open areas		Been on isolation	
Physical/psychological abuse		Body piercings/tattoos		History of MRSA or infectious disease	
ADHD		Petechia/bruising		Sexually transmitted disease	

Sensory deficits		GI		GYN (females)	
Vision changes		Reflux		LMP/last menstrual period	
Hearing deficit		Ulcer		Possibility of pregnancy	
Hearing aids		Hiatal hernia		Post-menopausal (not menstruating longer than 1 year)	
Macular degeneration		Hepatitis			
Glaucoma		Ostomy		Breastfeeding	
Had surgery for glaucoma		Change in bowel habits		Other	
Cataracts		Diverticular disease			
Had surgery for cataracts		Crohn's disease/colitis			
Other		Constipation			
		IBS/irritable bowel syndrome			
		Other			

List of all surgeries	Date performed

Have you had any problems with anesthesia?

Any family history of malignant hyperthermia?

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