



Lankenau Medical Center
 Bryn Mawr Hospital
 Paoli Hospital
 Riddle Hospital



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		Pneumonia	
Seizures		Aneurysm		COPD/emphysema	
Migraines/headaches		Heart attack		Asthma	
Swallowing/speech difficulty		Heart failure		Acute bronchitis	
Head injury/concussion		Murmur/leaky valve		Chronic cough	
Confusion/dementia		Chest pain/AFib		Snoring	
Blackouts/fainting/dizziness		Irregular pulse/AFib		Sleep apnea	
Numbness/tingling		Circulation problem		CPAP	
Head injury		Phlebitis/blood clots		TB	
Memory changes		Pacemaker/defibrillator		Oxygen-how many liters	
Other		High cholesterol		Seasonal allergies	
		Cardiovascular intervention/cardiac catheterization/stents		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	
Macular degeneration		Hepatitis		(not menstruating longer than 1 year)	
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?	Patient ID
Any family history of malignant hyperthermia?	

