

**SUMMIT MEDICAL ASSOCIATES, P.C.
MEDICAL HISTORY & ANESTHESIA EVALUATION**

Name: _____ Age: _____ Ht: _____ Wt: _____ Date: _____

ALLERGIES AND REACTIONS: Yes No If yes, list with reactions: _____

DRUG HISTORY:

Medication/drugs taken within the last month, including psychotropic, diuretics, B/P medication, cardiac, steroids, diet pills, etc.

Yes No If yes, list: _____

Recreational/street drugs taken within the last month, including marijuana, cocaine, etc.

Yes No If yes, list: _____

DISEASE HISTORY:

Do you have any infectious diseases now? _____

Do you have or have you had any of the following?

Yes	No	Vascular:	Yes	No	Respiratory:	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Bladder or kidney trouble
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or attack	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or TIA	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers or stomach problem
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Colds, Flu	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	Yes	No	Smoker	<input type="checkbox"/>	<input type="checkbox"/>	Breast Lump or Tumor
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding or clotting problems	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Illness	Yes	No	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Sickle-cell	<input type="checkbox"/>	<input type="checkbox"/>	Unusual Muscle Weakness in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Liver problem, Hepatitis, Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Rh negative blood	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HIV-AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Other than listed: _____	<input type="checkbox"/>	<input type="checkbox"/>	Seeing Psychiatrist (now/past)	<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia
								Genital Warts

ANESTHESIA EVALUATION:

Yes **No** Type of anesthesia requested: General _____ Local _____ MAC (Local with sedation) _____

1. List any serious illnesses (present or past): _____

2. List any previous surgeries: _____

3. Have you or any relatives had any problem with a prior anesthetic?
 Breathing Difficulty High Fever High or Low B/P Prolonged Paralysis Jaundice Nausea

4. Are you wearing contact lenses now? (Day of Surgery) Yes No _____

5. Do you have any False Capped Loose or Chipped Teeth? Location: _____

6. Do you smoke? How much? _____

7. Alcohol? Drugs? How much? _____

8. Do you have any physical restrictions or limitations? Back or neck problems or injuries? Yes No
 Explanation _____

9. Do you have asthma, wheezing or cough? _____

10. Do you have shortness of breath or chest pain on exertion? _____

11. Do you have any objection to blood transfusion should there be a life threatening emergency? _____

FAMILY MEDICAL HISTORY: Has anyone in your family ever had any of the following:

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complication with anesthesia Heart or kidney disease Cancer
 Genetic conditions Diabetes Pregnancy problems
 High blood pressure Tuberculosis Emotional problems

Comments: _____

OBSTETRICAL/GYNECOLOGICAL HISTORY:

Yes	No	Yes	No	Yes	No	Results of Last Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Full Term <input type="checkbox"/> Stillbirth (20-36 wks) <input type="checkbox"/> Spontaneous Termination/ <input type="checkbox"/> Premature <input type="checkbox"/> Full Term (>36 wks) <input type="checkbox"/> Induced Termination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Date of: _____
 Last delivery _____
 Last abortion/miscarriage _____
 Last PAP smear _____
 Last pelvic exam _____

Please list the number of: _____
 Full term deliveries _____
 Premature deliveries _____
 Abortions, wks. gest. _____
 Miscarriages, wks. gest. _____

Ectopic pregnancies, wks. gest. _____
 Date of last fetal death _____
 Number of living children _____
 Date of last live birth _____

Did you have any problems with previous pregnancies and/or pregnancy terminations? _____
 What facility: _____
 Birth Control Method at Time of Conception: _____