Washington Plastic Surgery Group, LLC

Anesthesia Service

PRE-ANESTHESIA FORM

PATIENT: _____

(Please print name clearly)

Elective or emergency anesthesia may be required during hospitalization.
Completion of this form will enable us to care for you.

A. DO YOU NOW OR HAVE YOU HAD A SIGNIFICANT HISTORY OF:

	No	Yes	Not Sure
1. Heart disease	☐	☐	☐
2. High blood pressure	☐	☐	☐
3. Lung disease (asthma, emphysema, etc.)	☐	☐	☐
4. Liver disease (jaundice, hepatitis, etc.)	☐	☐	☐
5. Kidney problems (other than infections)	☐	☐	☐
6. Diabetes	☐	☐	☐
7. Stroke/Convulsion	☐	☐	☐
8. Thyroid problem	☐	☐	☐
9. Psychiatric problems	☐	☐	☐
10. Neurologic or muscular problems	☐	☐	☐
11. Nausea/vomiting after surgery/anesthesia	☐	☐	☐
12. Anesthesia within one year	☐	☐	☐
13. An anesthesia complication	☐	☐	☐
14. A relative with an anesthetic complication	☐	☐	☐
15. A religious objection to a blood transfusion	☐	☐	☐
16. An objection to a general anesthetic	☐	☐	☐
17. An objection to a spinal anesthetic	☐	☐	☐
18. An upper respiratory infection (cold)	☐	☐	☐
19. Shortness of breath at rest	☐	☐	☐
20. Are you pregnant now	☐	☐	☐
21. Loose or capped teeth or dentures in place	☐	☐	☐
22. Smoke	None ☐ OR	packs/day	_____
23. Recent drug use (alcohol, cocaine, marijuana, PCP, steroids)	☐	☐	☐
24. Malignant hypothermia	☐	☐	☐
25. High fever after surgery	☐	☐	☐

B. OTHER INFORMATION:

1. **MEDICATIONS:** _____
   _____
   _____
   _____

2. **ALLERGIES:** _____
   _____
   _____

3. **WEIGHT:** _____ **HEIGHT:** _____ **AGE:** _____

PATIENT SIGNATURE: _____

PHYSICIAN COMMENTS

PMH:

PSH: