ACWC Medical History & Anesthesia Evaluation

List all allergies?_____

Have *you* ever had any of the following conditions?

Yes	No		Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Low Blood Pressure	☐	☐	Bronchitis
☐	☐	Bleeding or Clotting disorders	☐	☐	Fibroids	☐	☐	Cold, Flu
☐	☐	Heart Disease or Attack	☐	☐	Rheumatic Fever	☐	☐	TB
☐	☐	Stroke or TIA	☐	☐	Varicose Veins or other Vessel conditions	☐	☐	Emphysema
☐	☐	Heart Murmur	☐	☐	Autoimmune Disease (Lupus, e.g.)_____	☐	☐	Glaucoma
☐	☐	Mitral Valve Prolapse	☐	☐	Bladder or Kidney disease	☐	☐	Ovarian Cysts
☐	☐	Diabetes Type _____	☐	☐	Hypoglycemia (low blood sugar)	☐	☐	Endometriosis
☐	☐	Hepatitis Type_____	☐	☐	Liver problems (Cirrhosis, eg.)	☐	☐	PCOS
☐	☐	Anemia	☐	☐	Muscle Weakness in arms or legs	☐	☐	Gonorrhea
☐	☐	Sickle-cell	☐	☐	Ulcers or stomach condition	☐	☐	Herpes
☐	☐	Blood Transfusion	☐	☐	Breast Lump or Tumor	☐	☐	HIV-AIDS
☐	☐	Migraine Headaches with Aura	☐	☐	Cancer_____	☐	☐	Chlamydia
☐	☐	Last Seizure Date_____	☐	☐	Psychiatric Illness (depression, e.g.)	☐	☐	Genital Warts
☐	☐	Thyroid: Last Crisis_____ _____	☐	☐	See a Psychiatrist (now/past)	☐	☐	PID
☐	☐	Breastfeeding now	☐	☐	Other_____	☐	☐	Other_____

List Your Medicines _____

_____

Abnormal PAP(s) _____

Birth Control last used	***Pill Patch Ring Depo Shot IUD Implant (Nexplanon) Condoms None***
Birth Control you now want to use	***Pill Patch Ring Depo Shot IUD Implant (Nexplanon) Condoms None Tubal Ligation Hysterectomy***

Anesthesia Evaluation:

Yes	No		
☐	☐	1.	Last time you ate or drank? _____
☐	☐	2.	Any previous surgeries: _____
☐	☐	3.	Have you or any relatives had any of the following problems 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? _____

Has anyone in <u>your family</u> ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Complications with Anesthesia	☐	☐	Heart or Kidney disease	☐	☐	Cancer
☐	☐	Genetic Conditions	☐	☐	Diabetes	☐	☐	Pregnancy Problems
☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Emotional Problems

Emergency Contact Information

Name_____

Address_____

City, State, Zip Code_____

Relationship to Patient_____

Telephone#_____**Cell#**_____**Other**_____

Patient Verification: The above information is true and accurate to the best of my knowledge. I realize that the Physician(s) at ACWC will rely on the information I have given on this document and the information I provided when my appointment was scheduled.

Your Name (print):_____ **Your Signature:**_____**Date**_____

Reviewed by _____RN/CRNA/MD Date_____