



1490 E. Foremaster Dr. Bldg. C, St. George Ut. 84790 (435) 674-5230 Fax (435) 674-5231

Patient Name:					
Age:	Height:	Ft.	In.	Weight:	Primary Care Physician:

Y		N		SPECIAL CONSIDERATIONS	
		COMMUNICATION PROBLEMS HEARING / VISION		I HAVE DISCUSSED WITH MY SURGEON; THE NECESSITY AND APPROPRIATENESS OF THE PROPOSED PROCEDURE AS WELL AS ALTERNATIVE TREATMENTS. <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS: _____	
		PHYSICAL LIMITATIONS?			
		LATEX ALLERGIES: <input type="checkbox"/> NONE			
		MEDICATION ALLERGIES: <input type="checkbox"/> NONE			
		FOOD / OTHERS ALLERGIE <input type="checkbox"/> NONE			

LIST ALL CURRENT AND RECENT MEDICATIONS or ATTACH SEPERATE SHEET (INCLUDE PRESCRIPTIONS, EYE DROPS, & OVER-THE-COUNTER MEDS / VITAMINS AND THE DOSAGE)

LIST PREVIOUS HOSPITALIZATION OR OPERATIONS (INDICATE APPROXIMATE YEAR)

** HAVE YOU HAD A BAD REACTION TO ANESTHESIA		HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA <input type="checkbox"/> YES <input type="checkbox"/> NO			
DO YOU HAVE or HAVE YOU HAD	Y	N	HAVE YOU HAD	Y	N
DIABETES (Controlled by: Diet, Pills, or Insulin)			ANY ILLNESS, COLD, COUGH, OR FEVER IN THE LAST WEEK?		
HYPOGLYCEMIA (Low Blood Sugar)			ANY RECENT EXPOSURE TO COMMUNICABLE DISEASES?		
HEART PROBLEMS (Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Irregular heart Beat, EKG Changes, Angina, Ankle Swelling, Valve Replacement)			(FEMALES) IS THERE A POSSIBILITY YOU ARE PREGNANT? LAST MENSTRUAL PERIOD: _____		
BLOOD CLOTS, TRANSFUSION PROBLEMS			DO YOU DRINK ALCOHOLIC BEVERAGES? HOW OFTEN? _____ HOW MUCH? _____		
BLEEDING TENDENCY (Hemophilia)			DO YOU HAVE A HISTORY OF OR ARE YOU TAKING ANY RECREATIONAL DRUGS?		
HIGH BLOOD PRESSURE			DO YOU HAVE ANY OF THE FOLLOWING <input type="checkbox"/> BRACES <input type="checkbox"/> FALSE TEETH <input type="checkbox"/> BRIDGES <input type="checkbox"/> RETAINERS <input type="checkbox"/> LOOSE TEETH <input type="checkbox"/> CAPPED TEETH <input type="checkbox"/> CHIPPED TEETH		
STROKE (Weakness or Numbness on one side, Difficulty Speaking, Loss of Vision)					
LUNG PROBLEMS (Asthma, Chronic Cough, Pneumonia, Wheezing, Shortness of Breath, Emphysema, Abnormal chest X-ray)			DO YOU NEED A RELEASE FROM WORK		
LIVER PROBLEMS (Jaundice, Hepatitis)			PATIENT / SO SIGNATURE X		
SLEEP APNEA (Breathing Interruption During Sleep or Use Oxygen)					
RESTRICTIONS IN MOVEMENT					
DIFFICULTY OPENING MOUTH (TMJ)					

PAIN MANAGEMENT	PATIENT STICKER
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8.2 FORM Pain Management Anesthesia Questionnaire / 09.22.10			
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