This information is requested by your anesthesiologist. Please fill out this side as completely as you can. If you have any questions, please note them to discuss with your anesthesiologist.

Name_____ Age_____ Height _____ Weight_____ Sex M / F

Date of last physical exam _____ Last EKG _____

Previous Operations	When & Where	Type of Anesthesia: General	Nerve Block	Spinal/ Epidural	Local w/ Sedation	Complications?

Drug Allergies ☐ No ☐ Yes (list) _____

Latex Allergy ☐ No ☐ Yes

Family History of Anesthetic Complications? ☐ No ☐ Yes (describe) _____

Medicines Currently Taken (include vitamins/herbs/supplements) ☐ **None**

Name	Dose	Times Per Day	Name	Dose	Times Per Day

Check below if you have or have ever had any of the following: Leave the box blank if not applicable.

Heart/Vascular Problems	**Nerve Disease**	**Bleeding Problems**	**Dental / Vision / Hearing**
☐ Heart Attack	☐ Stroke	☐ Easy Bruising	☐ Dentures / Partial Plates
☐ Heart Failure	☐ Transient Ischemic Attack	☐ Nosebleeds	☐ Crowns / Bridge
☐ Coronary Artery Disease	☐ Numbness / Weakness	☐ Blood Transfusion	☐ Chipped Teeth
☐ Angina / Chest Pain	☐ Seizures	☐ Anemia	☐ Loose Teeth
☐ Abnormal ECG/Arrhythmia	☐ Headaches	☐ Blood clot in leg or lung	☐ Gum Disease
☐ Pacemaker	☐ Psychiatric Illness	**Thyroid / Liver / Kidney / GI**	☐ Contact Lenses
☐ Internal Cardiac Defibrillator	**Respiratory / Lung Problems**	☐ Hypothyroid	☐ Glasses
☐ Murmur / Valve Disease	☐ Asthma	☐ Hyperthyroid	☐ Hearing Aid
☐ Exercise Limitation	☐ Bronchitis	☐ Hepatitis	☐ Prosthesis
☐ Peripheral Vascular Disease	☐ COPD	☐ Diabetes	**Other**
☐ High Blood Pressure	☐ Pneumonia	☐ Kidney Disease	☐ Motion Sickness
☐ High Cholesterol	☐ Tuberculosis	☐ End Stage Renal Disease	☐ Fainting
Bone / Joint Problems	☐ Abnormal Chest X-ray	☐ Dialysis	☐ Drug / Substance Abuse
☐ Arthritis	☐ Heavy Snoring	☐ Ulcers	☐ Recent Infectious Exposure
☐ Back Problems	☐ Sleep Apnea	☐ Hiatal Hernia	☐ AIDS / HIV
☐ Steroid / Cortisone Use	☐ Recent Cold / Flu	☐ Acid Reflux (GERD)	☐ Cancer

Other medical problems _____

Do you drink alcohol? ☐ No ☐ Occasionally ☐ Daily - Amount per day _____

Are you pregnant?_____ Might you be pregnant?_____ Last menstrual period _____

How much do/did you smoke per day?_____ How many years?_____ Quit? (when)_____ Never smoked____

Do you have an Advanced Directive (Living Will or Durable Power of Attorney for Health Care? ☐ No ☐ Yes

Date _____ Time _____ Patient Signature _____

VALLEYCARE HEALTH SYSTEM
A not-for-profit health system

ADDRESSOGRAPH

ANESTHESIOLOGY SERVICES
HISTORY AND PHYSICAL EXAM