PHYSICIANS
Surgical Center

1840 Quentin Road • Lebanon, Pennsylvania 17042
Telephone (717) 272-0007 • FAX (717) 675-2247

PATIENT HEALTH HISTORY

Please complete the front of the pink forms and bring it with you to the Physicians Surgical Center on the day of surgery.

Name: _____ **Age:** _____ **Sex:** ❑ **Male** ❑ **Female**

Height: _____ **Weight:** _____ **Person taking you home/phone #** _____

Emergency contact name and number: _____

Family physician: _____ **Phone number:** _____

Do you or did you have any diseases Involving the following: (Check Yes or No and Circle the disease)

YES	NO	
		Heart: (heart attack/congestive failure/chest pain/irregular beat/ valve problems/rheumatic fever/surgery/other/pacemaker/defibrillator)
		Lungs: (asthma/bronchitis/wheezing/shortness of breath/ emphysema/TB/chest cold in the last six weeks/other)
		Kidneys: (dialysis/failure/infection/stones/others)
		Circulation: (high BP/phlebitis/clots/poor circulation/other)
		Diabetes: (diet controlled/pills/insulin)
		Thyroid: (under active/over active/other)
		Liver: (yellow jaundice/hepatitis/cirrhosis/mono/other)
		Nervous System (stroke/convulsions/paralysis/parkinsonism/ multiple sclerosis/myasthenia gravis/other)
		Psychiatric: (anxiety attacks/schizophrenia/depression/other)
		Digestive: (hiatal hernia/reflux/ulcers/indigestion/other)
		Teeth/Airway: (false/loose/caps/bridges/braces/retainers/ sleep apnea/trouble opening mouth)
		Contact Lenses: (soft/hard/extended wear) Removed
		Pregnancy: (any chance of being pregnant)
		Piercings: (all body piercings removed)
		History of Malignant Hyperthermia

YES	NO	
		Muscles/Joints: (neck/jaw/arthritis/scoliosis/other)
		Other Significant Medical History: (cancer/glaucoma/ Hepatitis/HIV (AIDS))
		Tobacco: (chew/smoke ___ packs/day ____ years/quit ___)
		Alcohol: (social _____ / daily _____ /quit _____)
		Street Drugs: (marijuana/cocaine/IV drugs)
		Blood Transfusion/Blood Products
		Have you taken Prednisone/Steroids within the last six months?
		Children Section Only: History of premature childbirth
		_____ _____ _____
		Anesthesia: have you had any problems with anesthesia in the past? Have any of your blood relatives had trouble with anesthesia? Do you have anything you want to discuss regarding your anesthesia?
		Special Needs: (cultural, physical, medical, communication barriers)

OTHER: _____

_____

ANY ASSISTIVE DEVICES: (please list below) _____

_____

_____

ALLERGIES: Medications / Latex / Other (please list below) _____

_____

_____

SURGICAL HISTORY: (Include all previous surgeries) Any metal implants? ❑ Yes ❑ No Where _____

_____

_____

_____

Form reviewed by nurse: _____ Date _____

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Anesthesia Consultation

Health History Summation: _____

MAC **GENERAL** **IV BLOCK**
SPINAL **EPIDURAL** **NERVE BLOCK**

ASA: **1** **2** **3**

Affirmation: All risks including allergic reactions, nausea, vomiting, aspiration, back pain, headache, dental trauma, loss of airway with prolonged apnea, cardiovascular collapse, and death have been discussed with the patient. The patient has been informed that the techniques and procedures may have to be altered to meet the needs of the clinical situation during the operation. The patient has been given the opportunity to ask questions and fully understands the above information. I have explained the purpose, nature and risks of alternative anesthetic techniques to the patient/patient's designee.

Anesthesiologist Signature: _____ M.D./D/O. Patient Signature: _____

Date: _____ Date: _____