Reset Form

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PATIENT HEALTH ASSESSMENT – PRE-ANESTHESIA CLINIC

Name:_____	**Height:** _____	**Weight:**_____

In the past year, how many times have you been admitted to a hospital? _____

Primary Care Provider Name and Number:_____

Check ANY that applies: ☐ Short of breath at rest ☐ Unable to exercise due to physical limitation
☐ Able to walk 1 city block (200 yards) ☐ Able to climb 1 flight of stairs without stopping ☐ 2 flights or more?
☐ Exercise regularly, if yes, How many times per week?_____ what type of exercise?_____
☐ Able to lay flat and still for 30 minutes (without shortness of breath, coughing or moving)?

Have you ever had any of the items below?	NO	YES	If YES, please give details and dates
Any surgery	☐	☐	
Any anesthesia problems	☐	☐	
Family history of anesthesia problems	☐	☐	
Currently pregnant	☐	☐	
Do you have an advanced directive	☐	☐	
☐ Heart attack ☐Heart stents ☐Heart surgery	☐	☐	When?
Chest / Heart pain / tightness: ☐ When walking ☐ At rest	☐	☐	☐ In last 3 months?
Heart failure history	☐	☐	Current symptoms:
Heart valves problems or surgery	☐	☐	Which valve?
Atrial fibrillation/ Irregular heartbeat Heartbeat too fast or too slow	☐	☐	Current symptoms:
Pacemaker or defibrillator	☐	☐	
Fainting / near fainting in the last year	☐	☐	
Other heart conditions	☐	☐	
High blood pressure	☐	☐	
Leg pain when walking due to blocked arteries	☐	☐	☐ stent placed in leg artery
Pulmonary hypertension	☐	☐	
Recent trouble breathing	☐	☐	☐with activity ☐At rest
Sleep Apnea ☐Using CPAP/BiPAP	☐	☐	
Pneumonia/ Bronchitis with fever or antibiotics use	☐	☐	☐ In last month?
Asthma ☐ history of ER visits or hospitalization	☐	☐	
COPD/Emphysema	☐	☐	
Wheezing	☐	☐	☐ If yes, in last month?
Daily cough ☐ Bring up phlegm daily	☐	☐	
Home oxygen	☐	☐	How much?
Current Tuberculosis	☐	☐	
Current fever, shaking chills, soaking night sweats	☐	☐	
TMJ/ Mouth/ jaw trouble?	☐	☐	
Difficulty with speech or swallowing	☐	☐	

PLACE PATIENT LABEL HERE

Have you ever had any of the items below?	NO	YES	If YES, please give details and dates
Acid reflux/Heart burn or Ulcer	☐	☐	
Liver disease or current yellow skin or eyes	☐	☐	
Cirrhosis or ascites	☐	☐	
Diabetes ☐Type I ☐Type II ☐ on insulin	☐	☐	Last A1C:
Thyroid Issues ☐Goiter ☐Hypo (low) ☐Hyper (high)	☐	☐	
Low kidney function/disease (other than stones)	☐	☐	If on dialysis, which days?
Blood count too high / too low(Anemia) (circle which)	☐	☐	
Excessive bleeding (please elaborate)	☐	☐	
Blood clots in legs / DVT or lungs / PE	☐	☐	
Blindness / Glaucoma (circle which)	☐	☐	
Cancer Type? Treatment?	☐	☐	When?
Organ Transplant which organ?	☐	☐	When?
Current skin infection or open wounds	☐	☐	
Ever told you have MRSA ☐treated	☐	☐	When?
Arthritis ☐with neck involvement	☐	☐	
Steroids, prednisone or immunotherapy (including IV)	☐	☐	In the last year?
HIV	☐	☐	
Autoimmune disease	☐	☐	
Stroke or TIA ☐remaining symptoms	☐	☐	When?
Neurologic disease, causing weakness	☐	☐	
Seizures	☐	☐	When was last one?
Current psychiatric care	☐	☐	
Significant memory loss / dementia	☐	☐	
Need help with your self-care at home (e.g. bathing)	☐	☐	
Need help with daily activities (e.g. running errands)	☐	☐	
Physical disability	☐	☐	
Prescription pain medications more than 2 months?	☐	☐	
Use a pain pump or stimulator? What type?	☐	☐	
Methadone / suboxone / buprenorphine / naltrexone	☐	☐	
Any street drug use in last 6 months? (not including marijuana) If yes: any IV use? ☐No ☐Yes	☐	☐	
Cigarette use: ☐Never ☐Current ☐Quit Other tobacco ☐Cigars ☐E-cigs ☐ pipe	☐	☐	If smoked cigarettes, how many years_____ Packs per day_____ If quit, when? _____
Number of alcoholic drinks in a typical week_____ ☐ some days have more than 3 drinks in a day	☐	☐	
Are you experiencing homelessness?	☐	☐	

PLACE PATIENT LABEL HERE

Current Medications (Including over the counter, dietary supplements, herbal medications), (OK to attach list):
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
Allergies (please describe reactions), (OK to attach list):
1
2
3
4
5

Comments (If need more space please attach more pages):

PATIENT SIGNATURE	PRINT NAME	DATE	TIME

PLACE PATIENT LABEL HERE