



PRE-REGISTRATION FORM

Please fill out and bring this form with you to be reviewed during your meeting with the anesthesia provider.

Name		Date of Surgery
Surgeon	Type of Surgery	Today's Date
Age	Race	Height
		Weight

Please list all prior surgeries and the type of anesthetics

Please list any particular problems with prior anesthesia

List all medications you are taking, along with their dosages

List any known allergies to drugs or medications

Person to contact for further information

Contact's Phone Number

Please review the following questions and be prepared to review during your pre-op interview (Circle only if the answer is YES)

Have you ever had: **Circle ONLY if YES**

- Heart attack or heart failure? Yes
- Heart surgery, by-pass or balloon procedure? Yes
- Heart catheterization? Yes
- Treadmill test or thallium scan? Yes
- Chest pains or angina? Yes
- High or low blood pressure? Yes
- Irregular heartbeat or murmur? Yes
- Diabetes? Yes
- Asthma, emphysema, shortness of breath? Yes
- TB or abnormal chest x-ray? Yes
- Thyroid problems? Yes
- Anemia, low blood, bleeding problems? Yes
- Jaundice, hepatitis, liver disease? Yes
- Glaucoma or eye problems? Yes
- Seizures, stroke or TIAs? Yes
- Fainting spells or blackouts? Yes
- Weakness, numbness of an extremity? Yes
- Back pain or trouble? Yes
- Kidney or renal disease? Yes
- Cancer of any kind? Yes
- Any complication (other than nausea/vomiting) with anesthesia? Yes
- Were you every told you had a difficult airway or breathing tube? Yes
- Any family member had trouble with anesthesia or Malignant Hyperthermia? Yes
- Allergies to latex products? Yes

Do you now have:

- Chipped, missing or loose teeth? Yes
- Dentures, removable bridges or capped teeth? Yes
- Chest pain or shortness of breath? Yes
- A cold or fever? Sinusitis? Yes
- Chronic or frequent cough? Yes
- Heartburn or hiatal hernia? Yes
- Any difficulty moving your neck? Yes
- Glasses, contacts or hearing aids? Yes
- Do you drink alcohol? Yes
- Do you smoke? Packs/day _____ Years _____
- How long since you last smoked? _____
- Are you pregnant? Yes No
- Last menstrual period _____
- List any other medical problems _____