

## Bartlesville Surgery Center

**INSTRUCTION:** Please read and check all questions with **YES** or **NO** . Fill in all other information.  
 Your answers are very important for the anesthesia provider to know. *This questionnaire will be kept **confidential**.*

**NAME:** \_\_\_\_\_ **HT:** \_\_\_\_\_ **WT:** \_\_\_\_\_ **AGE:** \_\_\_\_\_  
 (Birth weight if under age 2)

Do you have or have you had any of the following?

	YES	NO
A recent cold or flu _____		
Asthma, bronchitis, emphysema _____		
Tuberculosis _____		
Do you smoke _____		
<i>Amount in a day</i> _____		
<i>Number of years</i> _____		
Shortness of breath _____		
Rheumatic fever _____		
Heart Murmur _____		
High or low blood pressure _____		
Chest pain (angina) _____		
Heart attacks (infarction) _____		
Irregular heart beats _____		
Bleeding /Clotting disorders _____		
Sickle cell anemia _____		
Anemia or blood problems _____		
Jaundice or liver disease _____		
Hepatitis _____		
Hiatal hernia (stomach hernia) _____		
Infectious mononucleosis _____		
Back or neck trouble _____		
Convulsions or epilepsy _____		
Periodic dizziness/fainting _____		
Stroke _____		
Polio, paralysis, nerve damage _____		
Thyroid trouble _____		
Diabetes _____		
Low blood sugar _____		
Kidney trouble _____		
Were you a premature baby? _____		
AIDS / HIV Positive _____		
Are you an alcohol / drug abuser _____		
Have you fallen within the last 3 months? _____		
DID YOU RECEIVE A SURGICAL HOSPITAL BROCHURE? If YES did you read it? _____		

	YES	NO
Blood Transfusions _____		
Dentures, caps, loose teeth _____		
Have you had problems in the past with anesthesia? _____		
Have there been any anesthesia problems in any family members? _____		

Other health problems not mentioned, please list.  
 \_\_\_\_\_  
 \_\_\_\_\_

List any **PAST SURGERIES:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any current medications you are taking and the dosage (include daily amount of aspirin). \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Immunizations current? **Yes No**  
 If female, are you pregnant? **Yes No**  
 List first day of last period \_\_\_\_\_  
 Do you have a child under 6 mo.? **Yes No**

**DO YOU HAVE ANY OBJECTIONS TO ANY ASPECT OF ANESTHESIA**

ARE THERE OTHER QUESTIONS YOU WOULD LIKE TO ASK THE ANESTHESIA PROVIDER? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

PATIENT LABEL

Bartlesville Surgery Center

Allergy Form

*(Please fill out form and bring it with you on the day of surgery)*

If you are allergic to any medications please list them here: \_\_\_\_\_

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Are you allergic to Latex?       Yes       No

Are you allergic to Beta dine?       Yes       No

Are you allergic to shell fish?       Yes       No