Pre-Sedation Medical History Questionnaire

All information is private and confidential

NAME: _____ DATE OF BIRTH: _____ HT: _____ WT: _____

1. Have you been hospitalized or had any operations?

❑ NO ❑ YES If Yes, please list _____

2. Have you or your relatives had problems with sedation or anesthesia, including malignant hyperthermia?

❑ NO ❑ YES If Yes, please list _____

3. Are you currently taking any medications, or non-prescription drugs/supplements?

❑ NO ❑ YES If Yes, please list _____

_____

4. Do you have any drug allergies?

❑ NO ❑ YES If Yes, please list _____

5. Any other allergies (e.g. Latex, eggs, metal, hayfever):

❑ NO ❑ YES If Yes, please list _____

6. Please indicate if you have a history of the following:

❑ NO ❑ YES Heart problems (e.g. heart murmur, angina, irregular heart beat)

❑ NO ❑ YES High/low blood pressure/stroke

❑ NO ❑ YES Diabetes or hypoglycemia

❑ NO ❑ YES Asthma, Persistent cough, Tuberculosis

❑ NO ❑ YES Joint replacement surgery

❑ NO ❑ YES Hepatitis, jaundice or liver problems

❑ NO ❑ YES Kidney or thyroid disorders

❑ NO ❑ YES Bleeding disorder or anemia

❑ NO ❑ YES Fainting, dizziness, nervous disorders

❑ NO ❑ YES Epilepsy, seizures or convulsions

❑ NO ❑ YES Wear contact lenses

❑ NO ❑ YES Any condition that could affect your immune system (e.g. AIDS, HIV, leukemia)

If you indicated YES to any of the above please explain

_____

_____

7. Are you a smoker? ❑ NO ❑ YES If Yes, How many per day? _____

8. Women: Are you pregnant or nursing? ❑ NO ❑ YES

PATIENT'S SIGNATURE: _____ DATE: _____

FOR OFFICE USE

REVIEWED BY _____

ASA _____ BP_____ /_____ PULSE _____

OTHER FINDINGS_____