Specialty Anesthesia Partners
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Adult Medical History Form

Today's Date: _____ / _____ /_____
MM DD YYYY

Patient Identification

Patient Name:_____ DATE OF BIRTH: _____ / _____ /_____
(First Name) (Middle Name) (Last Name) MM DD YYYY

SEX: ☐ Male ☐ Female ☐ Other:_____

Current **HEIGHT**:_____ Current **WEIGHT**:_____

RACE: ☐ Asian ☐ American Indian/Alaska Native ☐ Black/ African American ☐Native Hawaiian/ Pacific Islander ☐ White/ Caucasian ☐ Other:_____

ETHNICITY: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Other:_____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

LEGAL CUSTODIAN

Patient is in the **legal custodial care** of: ☐ Self ☐ Mother Only ☐ Father Only ☐ Both Parents ☐ Other_____

Patient Contact Information

Address:_____
_____
_____
Phone:_____
Email:_____

Secondary Contact Information

Name:_____
Relationship:_____
Address: _____
_____
Phone:_____
Email:_____

EMERGENCY CONTACT (OTHER THAN SECONDARY CONTACT)

Name: _____Relationship: _____Phone:_____

MEDICAL HISTORY

Physician name: _____ Phone: _____
Specialist Name & type: _____ Phone: _____

1. Is the Patient in good health?	**Yes**	**No**
2. Has there been <u>any change</u> in the Patient's health in the last year?	**Yes**	**No**
3. Is the patient currently under the care of a physician for any condition?	**Yes**	**No**
4. Is the patient currently pregnant, nursing or peripartum?	**Yes**	**No**

MEDICATIONS

5. Does the patient currently take any prescriptions, over the counter medications, supplements, or recreational substances? **Yes** **No**
If yes, please list all medications, substances, over the counter medications, and supplements AND dosages
_____
_____

Allergies:

6. Does the patient have any allergies to drugs or medications? **Yes** **No**
If yes, please list with reactions:_____

7. Does the patient have any environmental, food, or latex allergies? **Yes** **No**
If yes, please provide details:_____

8. Please check if the patient *HAS or EVER HAD* any of the following medical conditions:
If no problems in that area, please check "none"

Cardiac	**Respiratory**	**Neurological/Muscular**
☐ Heart murmur	☐ Asthma or Reactive Airway	☐ Stroke
☐ Congenital Heart Defect/Disease	☐ Pulmonary Fibrosis	☐ Seizure or Epilepsy
☐ Long QT syndrome	☐ Bronchitis	☐ Brain Disease or condition
☐ Arrythmia or Irregular Heartbeat	☐ Pneumonia	☐ Spinal Cord disease or injury
☐ Cardiac arrest	☐ Pneumothorax	☐ Nervous system disease
☐ MI or Heart Attack or Angina	☐ Pulmonary embolism	☐ Muscular dystrophy
☐ Pacemaker/defibrillator	☐ Pulmonary Edema	☐ Neuromuscular problem
☐ Heart Valve disease/disorder	☐ Tracheal Esophageal Fistula	☐ Cerebral Palsy
☐ Pacemaker/defibrillator	☐ Aspiration	☐ Autonomic Dysreflexia
☐ Hypertension or Hypotension	☐ Tuberculosis	☐ Spinal Bifida
☐ LVAD	☐ Chronic Cough	☐ Hydrocephalus or VP shunt
☐ Coronary Artery Disease	☐ Interstitial Lung Disease	☐ Paralysis
☐ Heart Failure	☐ COPD	☐ Rhabdomyolysis
☐ Other_____	☐ Other_____	☐ Other_____
☐ None	☐ None	☐ None
Head and Neck	**Blood and Vascular**	**Endocrine**
☐ Tracheostomy	☐ Iron Deficiency Anemia	☐ Diabetes
☐ Tracheal Stenosis/Malacia	☐ Sickle Cell Anemia or Trait	☐ Thyroid disease
☐ Cleft Lip or Cleft Palate	☐ Aneurysm	☐ Hormone disorder
☐ Sleep Apnea (Obstructive)	☐ Vasculitis or Kawasaki disease	☐ Adrenal Insufficiency
☐ Enlarged Tonsils or Adenoids	☐ Hemophilia or Van Willebrand's	☐ Growth Disorder
☐ Nasal Disorder	☐ Bleeding or Clotting Disorder	☐ Bone problems or disease
☐ Craniofacial Disorder	☐ Thrombosis or Embolism	☐ Pituitary/Hypothalamus disease
☐ Recurrent ear infections	☐ Porphyria	☐ Obesity
☐ Rhinitis or Sinus disease	☐ Carotid stenosis	☐ Sleep disorder
☐ Eye Disease	☐ Peripheral Vascular Disease	
☐ Other_____	☐ Other_____	☐ Other_____
☐ None	☐ None	☐ None
GIU	**Psychiatric**	**Genetic and Systemic**
☐ GERD or Reflux disease	☐ ADD/ADHD	☐ Down Syndrome
☐ Esophagitis	☐ Autism	☐ Genetic syndrome or disorder
☐ Ulcers	☐ Behavioral Disorder	☐ Mitochondrial disorders
☐ G-tube or other Feeding tubes	☐ Intellectual Disability	☐ Physical disorder
☐ Gastro-Intestinal Disease	☐ PTSD	☐ Cancer
☐ Hepatitis	☐ Anxiety	☐ Radiation or Chemotherapy
☐ Liver Disease	☐ Psychosis	☐ Burn History
☐ Liver Failure or Cirrhosis	☐ Neurodevelopmental disorder	☐ Sensory disease/disorder
☐ Kidney Disease		☐ Organ transplant
☐ Dialysis		☐ HIV or Infectious Disease
☐ Other_____	☐ Other_____	☐ Other_____
☐ None	☐ None	☐ None

9. Please detail any of the above marked in question #7 OR any other/additional medical conditions the patient has or had:

_____
_____
_____

HOSPITALIZATIONS AND SURGERIES

10. Has the patient EVER been admitted to a Hospital OR undergone any Surgery? **Yes** **No**

If yes, please list:

Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____

SEDATION AND ANESTHESIA HISTORY

11. What is the reason the patient is being referred for General Anesthesia or Sedation? (check all that apply)

☐Anxiety/Fear ☐Uncooperative Behavior ☐ Physical limitations ☐ Significant Gag Reflex
☐Extensive treatment needs ☐Medical Risk Factors ☐ Special Needs ☐ Other_____

12. Has the patient ever had any Sedation or General Anesthesia for any reason? **Yes** **No**

If yes, please detail:_____

13. Did the patient have any adverse reaction or complication with their anesthesia? **Yes** **No**

If yes, please detail:_____

14. Has the patient ever experienced any of the following anesthesia issues:

Malignant Hyperthermia	Yes	No	Difficult intubation	Yes	No
Pseudocholinesterase problem	Yes	No	Difficult IV	Yes	No
Hospital or ICU Transfer	Yes	No	Difficult airway	Yes	No
Respiratory Problem	Yes	No	Prolonged intubation	Yes	No
Cardiac arrest	Yes	No	Delayed Awakening	Yes	No
MI or Stroke	Yes	No	Nausea and Vomiting	Yes	No
Clot or Embolism	Yes	No	Emergence Delirium	Yes	No
Anaphylaxis/Allergy	Yes	No	Physical Injury	Yes	No
Hemorrhage	Yes	No	Failed sedation	Yes	No
Nerve Injury	Yes	No	Other	Yes	No

FAMILY HISTORY

15. Do ANY BLOOD RELATIVES for the patient have or ever had any of the listed problems?

Anesthesia Problems	Yes	No	Cardiomyopathy	Yes	No
Malignant Hyperthermia	Yes	No	Long QT syndrome	Yes	No
Pseudocholinesterase def.	Yes	No	Muscular Dystrophy	Yes	No
Congenital Heart Disease	Yes	No	Neuromuscular disease	Yes	No
Sudden Cardiac Death	Yes	No	Porphyria	Yes	No
Bleeding or Clotting disorder	Yes	No	Genetic condition	Yes	No
Sickle Cell Anemia Disease	Yes	No	Other	Yes	No

SOCIAL HISTORY

16. Please check any of the following that pertain to the Patient's social history, or check NONE if not applicable:

☐Smoking/Tobacco exposure ☐Homelessness ☐ Malnutrition / Food insecurity
☐Current Domestic Violence / requesting HELP now ☐Abuse History ☐Significant Life Hardship
☐Do Not Resuscitate Order (DNR) ☐Drug use/exposure ☐Alcohol abuse
☐Other:_____ ☐NONE

REVIEW OF SYSTEMS

17. Please Check box for any problems the Patient has. If no problems in that area now, check "no problems"

Constitutional:	☐ **no problems**
☐ Fever ☐ Chills ☐ Fatigue ☐ Unexplained weight loss/gain ☐ Excessive thirst ☐ Sleep problems	
Cardiovascular:	☐ **no problems**
☐ Chest pain ☐Palpitations ☐Exercise intolerance ☐Shortness of Breath on Exertion ☐Fast/Slow heartbeat	
Respiratory:	☐ **no problems**
☐ Cough ☐ Short of breath ☐ Chest tightness ☐ Wheeze ☐ Coughing blood	
Neurologic:	☐ **no problems**
☐ Seizures ☐ Headaches ☐Weakness ☐ Tremors ☐ Numbness ☐ Fainting ☐ Dizziness ☐ Vision changes	
Musculoskeletal:	☐ **no problems**
☐Muscle pain ☐Joint pain ☐Swelling ☐ Bone pain ☐ Neck stiffness ☐ Movement limitations	
GI/GU:	☐ **no problems**
☐ Nausea ☐vomiting ☐diarrhea ☐ Constipation ☐blood in stool ☐ Abdominal pain ☐ Changes in urination	
Ear, Nose, and Throat:	☐ **no problems**
☐ Mouth-breathing ☐ Snoring ☐ Ear pain ☐ Runny nose ☐ Nosebleeds ☐Sore throat ☐ neck masses	
Psychiatric/emotional:	☐ **no problems**
☐ Behavior changes ☐Anger/Violence ☐ Self-injurious behavior ☐ Changes in alertness or attention	
Integumentary:	☐ **no problems**
☐ itching ☐rashes ☐recent wounds ☐nodules ☐tumors ☐eczema ☐swellings ☐masses ☐Brusing	
Heme/Lymph/ID:	☐ **no problems**
☐Prior transfusion ☐Low blood cell counts ☐immune deficiency ☐infectious disease ☐Easy bleeding	
Dental:	☐ **no problems**
☐ Loose teeth ☐missing teeth ☐difficulty opening mouth ☐limited Jaw range of motion	

ATTESTATION

I certify that I have read and understood the above form.

I understand the importance of a complete and truthful health history and that my Anesthesia Care Team will rely on this information for safe treatment. I understand failure to disclose true and complete information may result in serious and/or significant health consequences. I affirm I will not hold my Dentist, Anesthesiologist, or any other member of the staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

I affirm that the information given on this form is accurate and complete to the best of my ability.

Signature of Patient OR Legal Guardian: _____ Date: _____

Print Name:_____ Relationship (if applicable)_____

I Have Reviewed and Discussed the completed Medical History Form.

Provider Signature: _____ Date: _____