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

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Please list any particular problems with prior anesthesia

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List all medications you are taking, along with their dosages

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List any known allergies to drugs or medications

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Person to contact for further information

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Contact's Phone Number

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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 TIA's?	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_____________________________

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