A Division of Drummond Medical Group, Inc.
1111 N. China Lake Blvd. · Ridgecrest, CA 93555-3131 · Fax (760) 446-8181 · Phone (760) 446-8100

ANESTHESIA PRE-OPERATIVE INFORMATION

Please check (√) correct response

Name________________________________Height___________________________ Weight________________________

YES	NO		
❑	❑	1.	Do you take PILLS or MEDICINE? Please list them: ____
❑	❑	2.	Do you take ASPIRIN or any medication that contains aspirin on a regular basis? How much?_________________________For how long?_________________________
❑	❑	3.	Within the last 3 weeks have you taken any of the following HERBAL PRODUCTS: ❑ St. John's Wort ❑ Ginko Biloba ❑ Ginseng
❑	❑	4.	Have you ever had a BLEEDING TENDENCY?
❑	❑	5.	Do you have a bad reaction or ALLERGY to any ❑ MEDICINE or ❑ LATEX? List the medicines:_________________________
		6.	Do you have or have you ever had:
❑	❑		a) THYROID or GOITER problems?
❑	❑		b) DIABETES: ❑ Special Diet ❑ Oral Medicine ❑ Insulin-What kind_________Dose_________
❑	❑		c) EPILEPSY-unconsciousness or convulsions?
❑	❑		d) Unusual MUSCLE WEAKNESS in arms or legs?
❑	❑		e) HIGH BLOOD PRESSURE?
❑	❑		f) STROKE?
❑	❑		g) HEART DISEASE:❑ Heart Attack ❑ Rheumatic Fever ❑ Scarlet Fever ❑ Chest Pain ❑ Irregular Heart Beat ❑ Other_________________________
❑	❑		h) LUNG PROBLEMS: ❑ Bronchitis ❑ Pneumonia ❑ Asthma ❑ Emphysema ❑ Cough ❑ Shortness of Breath ❑ Other_________________________
❑	❑		i) KIDNEY DISEASE:❑ Kidney Failure ❑ Kidney Stones ❑ Frequent Bladder Infections
❑	❑		j) HEPATITIS or JAUNDICE – When?_________________________
❑	❑		k) ANEMIA – When?_________________________
❑	❑	7.	Is there any chance that you are PREGNANT? Date of last menstrual period__________________
❑	❑	8.	Have you had problems with prior anesthesia? ❑Nausea/Vomiting ❑Jaundice ❑ Breathing Difficulty ❑ High Fever ❑ Drop in Blood Pressure ❑ Other_______________
❑	❑	9.	Has any member of your family ever had problems with anesthesia? What?____________________
❑	❑	10.	Have you had an ABNORMAL chest x-ray or electrocardiogram (EKG)?
❑	❑	11.	Do you have: ❑ Hearing Aide ❑ Contact Lenses ❑ Dentures ❑ Partial Plate ❑ Capped Teeth ❑ Chipped Teeth ❑ Loose Tooth–Where in your mouth?____________________
❑	❑	12.	Do you SMOKE? How much?____________________ For how long?____________________
❑	❑	13.	Do you drink ALCOHOLIC BEVERAGES? How much?____________________
❑	❑	14.	Have you had a RUNNY NOSE, COUGH, SORE THROAT or FEVER in the last 2 weeks?
❑	❑	15.	Have you had any previous surgeries? LIST TYPE OF SURGERY AND APPROXIMATE YEAR: ____ ____
❑	❑	16.	In an emergency situation would you object to a blood transfusion?
❑	❑	17.	Have you ever had any broken bones of your face, neck or back?
❑	❑	18.	Do you have: ❑ TMJ problems ❑ Arthritis ❑ Back Trouble ❑ Limited range of neck motion
❑	❑	19.	Is there any illness or condition that we should be aware of?____________________

I understand that I am not to eat, drink, smoke or chew tobacco for 8 hours before surgery, and I understand that I will not be able to drive myself home after surgery. To the best of my knowledge I have answered these questions accurately.

Signature: ____ Date:____________________________

(Patient/Parent/Guardian/Conservator)