Please fill in all highlighted areas and mail to The Williams Center

New England Laser and Cosmetic Surgery Center

Dept. of Anesthesia Pre-Operative Patient History

Patient Name____ Height________ Weight________ Age_______

Procedure____

____ Date of Procedure_______________

Primary Care Doctor:____ MD Phone Number________________

See Medication Reconciliation Sheet for all Medication and Allergies

List prior Surgeries and any adverse effects None { }

Answer the following to the best of your ability	YES	NO	Explain all "yes" answers
1. Have you ever had any complications with anesthesia?			
2. Is there a family history of Malignant Hyperthermia?			
3. Did you or do you smoke cigarettes?			
4. Do you drink Alcohol and how much?			
5. Did you ever use Cocaine or other recreational drugs?			
6. Do you have a history of High Blood Pressure?			
7. Have you ever had a Heart Attack?			
8. Do you ever have chest pain or Angina?			
9. Have you ever had Heart Failure?			
10. Do you have a pacemaker or defibrillator?			
11. Do you have Asthma? **If yes**, Complete Asthma assessment form			
12. Do you have Bronchitis, Emphysema or other Chronic Lung Disease?			
13. Do you get short of breath walking up one flight of stairs?			
14. Have you ever been told you have Sleep Apnea?			
15. Have you ever had a Seizure, Stroke or TIA (mini-stroke)?			
16. Do you have any numbness or tingling of your arms or legs?			
17. Do you have any Psychiatric or Mental Health Problem?			
18. Do you have Diabetes? If so, in what manner is it controlled?			
19. Do you have a history of Hepatitis, Jaundice or Liver Disease?			
20. Do you have a Hiatal Hernia, Gastric Reflux or Heartburn?			
21. Do you have any Thyroid Disease?			
22. Do you have a history of Kidney Disease?			
23. Do you bruise easily or have a history of Anemia?			
24. Do you have Sickle Cell Anemia or trait?			
25. Do you have Arthritis and where?			
26. Do you have a history of Lower Back Pain?			
27. Do you have any Loose Teeth, Caps or Dentures?			
28. Is it possible that you are Pregnant?			Date of LMP

29 Patient's Signature Date

ANESTHESIA USE ONLY

Pertinent Physical Findings:	
Anesthesia plan ASA I II III IV V E	**Post-operative Evaluation**
{ } General Anesthesia { } Monitored Anesthesia Care	{ } Vital Signs stable
	{ } Alert and Oriented
	{ } No anesthetic complications { } Anesthesia related complications & treatment plan
Physician's Signature Date	
Pre-operative Evaluation { } No Change in History	Treatment Plan:
Physician's Signature Date	Physician's Signature Date