

MEDICAL HISTORY AND PRE-ANESTHESIA QUESTIONNAIRE

Name: _____ **Date of Birth:** ____/____/____ **Age:** ____
Last Name First Name Initial
Sex: FEMALE / MALE **Height:** _____ **Weight:** _____

I. MEDICAL HISTORY

Do you have any of the following:

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble –murmur, palpitations (arrhythmia), pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain (angina), heart attack, heart failure |
| <input type="checkbox"/> | <input type="checkbox"/> | Scarlet fever, rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma, T.B., lung problems, shortness of breath with walking |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder, anemia, clotting problems, phlebitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure, epilepsy, convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells, blackouts, stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent or severe headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid condition, goiter |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice, hepatitis, liver problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney, bladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor wound healing, radiation treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal response to cold, Raynaud’s disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis, scleroderma, collagen disease, lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin pigment problems, keloid, poor scarring |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever blisters, cold sores, herpes simplex |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent infections or boils |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Significant emotional problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric care |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent fever or cold |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant now? |

II. PAST NASAL HISTORY

Medical History: Allergies _____
Nasal Medications _____
Nasal Fractures _____

Have you had any fillers injected into nose (*Restylane, Juvederm, Artecoll, Radiesse, etc.*) **YES / NO** If yes, when? _____

Please list ANY and ALL Nasal Surgeries: (<i>including Septoplasty, Rhinoplasty, etc.</i>)	YEAR	GENERAL/LOCAL ANESTHETIC

III. PAST MEDICAL HISTORY

Have you had any illnesses of the following: (please circle)

Heart	Lungs	Kidneys	Chest	Stomach	Eyes
Ears	Nose	Throat	Brain	Intestines	Arms
Hands	Legs	Nerves	Reproductive System		

Operations/ Injuries:

_____	Year	General/ Local Anesthetic
_____	Year	General/ Local Anesthetic

IV. RECENT EXAMINATIONS

	YES	NO	DATE
History and Physical	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	_____
EKG (Electrocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lab work	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are you under medical treatment? If yes, please explain:

V. MEDICATIONS

Are you sensitive or allergic to:

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Local/ General Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Adhesive Tape

Any other medication or food allergies – please list:

Are you taking or have you taken in the last 6 months any of the following:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or aspirin containing products?	<input type="checkbox"/>	<input type="checkbox"/>	Steroids, cortisone or ACTH?
<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers or sedatives?	<input type="checkbox"/>	<input type="checkbox"/>	Anticoagulants, blood thinners?
<input type="checkbox"/>	<input type="checkbox"/>	Insulin?			
<input type="checkbox"/>	<input type="checkbox"/>	Any other medication, drugs or eye drops?	_____		

VI. SOCIAL HISTORY

Approximate daily consumption of : Alcohol_____ Tobacco_____ Coffee_____

VII. FAMILY HISTORY

Has any relative ever had:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis, scleroderma, lupus
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Mental disease
<input type="checkbox"/>	<input type="checkbox"/>	Reaction to anesthesia			

VIII. ANY OTHER INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW?

*If any of the above information changes, please inform the doctor.

Form completed by: _____ Date: _____
(Patient's Signature)