



Valley Pain Center  
 Masons Mill Park II  
 1800 Byberry Road, Suite 1101  
 Huntingdon Valley, PA 19006  
 phone: 215-947-7992 | fax: 215-947-7969  
 www.ValleyPainCenter.com

## Patient Anesthesia History

Please complete the following information. This information will assist the anesthesia staff at Valley Pain Center in making decisions regarding your care while a patient at the Center.

### Health History

<b>Anesthesia History</b>	<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Difficulty Awakening <input type="checkbox"/> Family history of anesthetic complications <input type="checkbox"/> Malignant Hyperthermia <input type="checkbox"/> Other <input type="checkbox"/> None		
<b>Airway &amp; Teeth</b>	<input type="checkbox"/> Caps <input type="checkbox"/> Bridges/False teeth <input type="checkbox"/> Loose teeth <input type="checkbox"/> Braces/Retainers <input type="checkbox"/> Snoring <input type="checkbox"/> Other <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Trouble opening mouth <input type="checkbox"/> Mouth or Tongue piercings <input type="checkbox"/> None		
<b>Tobacco</b>	<input type="checkbox"/> Smoking <input type="checkbox"/> packs/day for <input type="checkbox"/> year(s) <input type="checkbox"/> Quit <input type="checkbox"/> yrs <input type="checkbox"/> None		
<b>Alcohol/</b>	<input type="checkbox"/> Social <input type="checkbox"/> Daily <input type="checkbox"/> Quit <input type="checkbox"/> year(s) <input type="checkbox"/> None		
<b>Drugs</b>	<input type="checkbox"/> Social <input type="checkbox"/> Daily <input type="checkbox"/> Quit <input type="checkbox"/> year(s) <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> IV Drugs <input type="checkbox"/> None		
<b>Pregnancy</b>	Is there any chance you could be pregnant? (a yes response will result in a pregnancy test) <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Heart</b>	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Chest pain or angina <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Lungs filled w/water <input type="checkbox"/> Valve problems <input type="checkbox"/> Pacemaker <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Other		
<b>Lungs</b>	<input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> TB <input type="checkbox"/> Chest cold in the last six weeks <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Cough <input type="checkbox"/> Other		
<b>Kidneys</b>	<input type="checkbox"/> Stones <input type="checkbox"/> Infection <input type="checkbox"/> Failure <input type="checkbox"/> Dialysis <input type="checkbox"/> Other <input type="checkbox"/> None		
<b>Neurological</b>	<input type="checkbox"/> Stroke <input type="checkbox"/> Migraines <input type="checkbox"/> Convulsions <input type="checkbox"/> Fainting <input type="checkbox"/> Paralysis <input type="checkbox"/> Other <input type="checkbox"/> None		
<b>Diabetes</b>	<input type="checkbox"/> Insulin <input type="checkbox"/> Pills <input type="checkbox"/> Diet <input type="checkbox"/> None		
<b>Circulation</b>	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Phlebitis <input type="checkbox"/> Clots <input type="checkbox"/> Other <input type="checkbox"/> None		
<b>Thyroid</b>	<input type="checkbox"/> Under active <input type="checkbox"/> Over active <input type="checkbox"/> Thyroid surgery <input type="checkbox"/> Other <input type="checkbox"/> None		
<b>Muscles &amp; Joints</b>	<input type="checkbox"/> Muscle disease <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Neck problems <input type="checkbox"/> Scoliosis <input type="checkbox"/> Other <input type="checkbox"/> None		
<b>Digestive</b>	<input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Ulcer <input type="checkbox"/> Reflux <input type="checkbox"/> Bleeding <input type="checkbox"/> Indigestion <input type="checkbox"/> Other <input type="checkbox"/> None		
<b>Liver</b>	<input type="checkbox"/> Yellow jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Mono (Active) <input type="checkbox"/> Other <input type="checkbox"/> None		
<b>Psychiatric</b>	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other <input type="checkbox"/> None		
<b>Other</b>	<input type="checkbox"/> Sinusitis <input type="checkbox"/> Glaucoma <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Cancer <input type="checkbox"/> Jehovah's Witness <input type="checkbox"/> Bruise easily <input type="checkbox"/> Burn history <input type="checkbox"/> Low blood count/Anemia <input type="checkbox"/> Eye problems <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Other		
<b>ALLERGIES (Drugs, Latex, Dyes, Food)</b>	<b>REACTION</b>	<b>OPERATIONS (List previous surgeries)</b>	
<input type="checkbox"/> None	<input type="checkbox"/> None		
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
<b>PRESCRIPTION MEDICATIONS</b>	<b>DOSE/FREQUENCY</b>	<b>OTHER MEDICATIONS</b>	<b>DOSE/FREQUENCY</b>
<input type="checkbox"/> None		(including vitamins, herbs)	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I attest that the above information I have provided is true to the best of my knowledge

Patient Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Information provided by patient above, reviewed with patient with any additions as noted

Patient Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Valley Pain Centers physician to sign**