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

Anesthesia History	____Nausea/Vomiting ____Difficulty Awakening ____Family history of anesthetic complications ____Malignant Hyperthermia ____Other ____None
Airway & Teeth	____Caps ____Bridges/False teeth ____Loose teeth ____Braces/Retainers ____Snoring ____Other ____Difficulty swallowing ____Trouble opening mouth ____Mouth or Tongue piercings ____None
Tobacco	____Smoking ____packs/day for ____year(s) ____Quit ____yrs ____None
Alcohol/	____Social ____Daily ____Quit ____year(s) ____None
Drugs	____Social ____Daily ____Quit ____year(s) ____Marijuana ____Cocaine ____IV Drugs ___None
Pregnancy	Is there any chance you could be pregnant? (a yes response will result in a pregnancy test) ____Yes ____No
Heart	____Heart Attack ____Chest pain or angina ____Mitral Valve Prolapse ____Lungs filled w/water ____Valve problems ____Pacemaker ____Irregular heartbeat ____Coronary artery disease ____Other
Lungs	____Asthma ____Bronchitis ____Shortness of breath ____Wheezing ____Emphysema/COPD ____TB ____Chest cold in the last six weeks ____Sleep apnea ____Cough ____Other
Kidneys	____Stones ____Infection ____Failure ____Dialysis ____Other ____None
Neurological	____Stroke ____Migraines ____Convulsions ____Fainting ____Paralysis ____Other ____None
Diabetes	____Insulin ____Pills ____Diet ____None
Circulation	____High blood pressure ____Low blood pressure ____Bleeding disorder ____Phlebitis ____Clots ____Other ____None
Thyroid	____ Under active ____Over active ____Thyroid surgery ____Other ____None
Muscles & Joints	____Muscle disease ____Osteoarthritis ____Rheumatoid arthritis ____Neck problems ____Scoliosis ____Other ____None
Digestive	____Hiatal hernia ____Ulcer ____Reflux ____Bleeding ____Indigestion ____Other ____None
Liver	____Yellow jaundice ____Hepatitis ____Cirrhosis ____Mono (Active) ____Other ____None
Psychiatric	____Anxiety ____Depression ____Schizophrenia ____Other ____None
Other	____Sinusitis ____Glaucoma ____Blood transfusion ____Cancer ____Jehovah's Witness ____Bruise easily ____Burn history ____Low blood count/Anemia ____Eye problems ____Rheumatic Fever ____Other

ALLERGIES (Drugs,Latex,Dyes,Food)	REACTION	OPERATIONS(List previous surgeries)
____None	____None	
______________________	______________	______________________
______________________	______________	______________________
______________________	______________	______________________
______________________	______________	______________________

PRESCRIPTION MEDICATIONS	DOSE/FREQUENCY	OTHER MEDICATIONS (including vitamins,herbs)	DOSE/FREQUENCY
____None			
______________________	______________	______________	______________
______________________	______________	______________	______________
______________________	______________	______________	______________
______________________	______________	______________	______________

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