72nd STREET MEDICAL ASSOCIATES , P.C.

ANESTHESIA ASSESSMENT **DATE:**

Name_____ _____Age_____SEX: M / F Ht.____Wt.____
last first

Do you have any: dentures, partial dentures, bridges, caps or loose teeth? (please circle)

YES	NO	
		Are you allergic to any medications? List:
		Have you ever been asleep for surgery?
		Have you or any one in your family had a problem with anesthesia?
		Do you take any medications? List:
		Do you take: Aspirin / Plavix / Coumadin? (please circle)
		Do you have high blood pressure?
		Do you have any heart problems?
		Heart failure in the past? Year_____
		Heart Attack? Year_____
		Heart Valve Problems?
		Bleeding Tendencies? Specify_____
		Other heart conditions? Specify_____
		Do you have any lung problems? Asthma / Emphysema/ COPD (please circle) **Other:**
		Do you have any neurological problems? (please circle) **Seizure Disorder / Stroke Year_____/ TIA Year_____/ Other_____**
		Have you ever had hepatitis? (please circle) Type: A B C
		Do you have diabetes? How long?_____
		Other gland problems? Which gland?_____
		Do you smoke? How many packs per day?_____Years smoked_____
		Do you drink alcohol? How much?_____
		Do you use any drugs?
		Do you have someone to take you home today?
		Have you had anything to drink in the past 4 hours? **If yes, what?_____How much (ounces)?_____**

Please sign here:_____Date:_____

Attending Sig:_____Date:_____