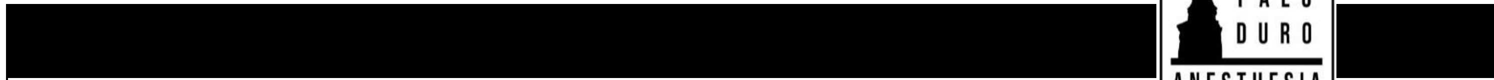

Check all that apply: Height: Weight:

Respiratory	GI/Liver	Renal/Endocrine
Asthma	Cirrhosis	Thyroid Disease
COPD/Emphysema	Hepatitis, Type ________	Cushing's Syndrome
Bronchitis	Ulcers	Renal Insufficiency
Wheezing	Hiatal Hernia	Adrenal Insufficiency
Pulmonary Embolism	Nausea/Vomiting	Diabetes
Recent Upper Respiratory Illness	Pancreatitis	Type 1 Type 2
Home Oxygen	Gallbladder Disease	Pituitary Disorder
History of Pneumonia	GERD/Heartburn	**Social**
Productive Cough	**Neuro/Muscular/GYN**	Tobacco Use
Shortness of Breath	Arthritis	Type ________________
Sleep Apnea	Back/Neck Pain	Quit _________________
Cardiovascular	Stroke/TIA	Alcohol Use
High Blood Pressure	Anxiety/Depression	Type ________________
Heart Disease	Headaches	Recreational Drug Use
Chest Pain	Dizziness	**Other**
History of a Heart Attack	Muscle Weakness	Bleeding Disorder
Cardiac Stents	Neuromuscular Disease	Cancer
Abnormal EKG	Paralysis	Chemotherapy
Pacemaker/ICD	Numbness in Extremities	Recent Steroid Use
AFib	Seizures	Sickle Cell/Trait
Heart Murmur	Hysterectomy	Immunosuppressed
Cardiologist	Date of Last Menstrual Cycle	o AIDS/HIV
________________________	__________	o Other
		______________________________
		______________________________
		______________________________

Physical Status

1 2 3 4 5 E

MEDICATION ALLERGIES:	SURGICAL HISTORY:
	Family History of Problems with Anesthesia

Patient Signature: ______________________________ CRNA Signature: ______________________________

Patient Sticker

This document was created from a previous encounter. It has been reviewed / updated to reflect current date patient data. See separate Assessment/ Post Anesthesia Care Note.

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