

DR. SPENCER WADE PLLC
DENTIST ANESTHESIOLOGIST

Anesthesia Medical History Form

Patient Information

Patient Full Name: _____ Date of Birth _____
Address: _____
Phone Number: _____ Email:_____

Approximate Weight (pounds)_____ Approximate Height (inches)_____

1. **Allergies:**
   - Do you have any allergies to medications, foods, latex, adhesive tape or other substances? (Circle one): Yes / No
   - If yes, please list: _____
2. **Current Medications:**
   - List all current prescription medications, inhalers, over-the-counter, vitamins, and supplements:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

3. **Past Surgeries and Anesthesia History:**
   - List all previous surgeries and dates (if known): _____
   - Have you ever had complications with anesthesia? (Circle one): Yes / No
   - If yes, please describe: _____
   - Has anyone in your family had complications with anesthesia? (Circle one): Yes / No
   - If yes, please describe: _____
4. **Lifestyle and Habits:**
   - Do you smoke or use tobacco products? (Circle one): Yes / No
   - If yes, how many per day? _____
   - Do you consume more than four alcoholic drinks weekly? (Circle one): Yes / No
   - If yes, how often? _____
   - Do you use recreational drugs? (Circle one): Yes / No
   - If yes, please specify: _____
5. **Previous Hospitalizations:**
   - Has the patient ever been hospitalized? (Circle one): Yes / No
   - If yes, please list all previous hospitalizations and dates (if known):
   - _____
6. **Current Doctors and Specialists**
   - Are you currently under the care of a PCP? (Circle one): Yes / No
   - If yes, please list name and contact number_____
   - Do you see any specialists? (Circle one): Yes / No
   - If yes, please list name and contact number

_____
_____
_____
_____

Born Prematurely	**Yes / No**
Are you Pregnant or Planning to become Pregnant?	**Yes / No**
Are you able to walk up a flight of stairs without taking a break?	**Yes / No**
Down Syndrome (Trisomy 21)	**Yes / No**
Cerebral Palsy	**Yes / No**
High Blood Pressure	**Yes / No**
Chest Pain	**Yes / No**
Heart Failure	**Yes / No**
Irregular Heart Beats/Heart Murmurs	**Yes / No**
Heart Valve Concerns	**Yes / No**
Previous Heart Attack	**Yes / No**
Pacemaker/Defibrillator	**Yes / No**
Previous Cardiac Surgery	**Yes / No**
Heart Stents	**Yes / No**
Enlarge Tonsils	**Yes / No**
Shortness of Breath/Difficulty Breathing	**Yes / No**
Snore Heavily at Night	**Yes / No**
Require Frequent Naps to Feel Rested	**Yes / No**
Obstructive Sleep Apnea	**Yes / No**
Seasonal Allergies	**Yes / No**
Asthma	**Yes / No**
Chronic Obstructive Pulmonary Disease/Emphysema	**Yes / No**
Do You Require Supplemental Oxygen?	**Yes / No**
Pulmonary Embolism	**Yes / No**
Previous Stroke	**Yes / No**
Dementia/Alzheimer's	**Yes / No**
Seizures or Epilepsy	**Yes / No**
ADHD or Autism	**Yes / No**
Depression	**Yes / No**
Anxiety	**Yes / No**
Liver Disease (Hepatitis, Cirrhosis)	**Yes / No**
Kidney Disease (Kidney Failure/Insufficiency, Kidney Stones)	**Yes / No**
Thyroid Disease (Hypothyroidism, Hyperthyroidism)	**Yes / No**
Diabetic	**Yes / No**
Muscle disorder (Hypotonia, Muscular Dystrophy, Contractures)	**Yes / No**
Acid Reflux	**Yes / No**
Intestinal Disease (Ulcer colitis, Chron's Disease)	**Yes / No**
Blood Disorder (Anemia, Thalassemia, Sickle Cell)	**Yes / No**
Bleeding disorders (Von Willebrand's, Hemophilia)	**Yes / No**
HIV or AIDs	**Yes / No**

Any other conditions that we should be aware of?_____

Consent and Acknowledgment By signing below, I confirm that the information provided is accurate and complete to the best of my knowledge. I understand that this information will be used to plan and provide safe anesthesia care. Withholding any information could jeopardize the patient's safety.

Patient Name:_____

Patient and/or Legal Guardian Signature: _____Date:_____