ANESTHESIA CONSENT

Modern anesthesia carries risk minimal enough that virtually everyone can be offered its benefits. However, every type of pain relief (anesthesia) has a certain risk which is known by your doctors. In most cases these risks are minimal. California law requires that doctors must inform you of the risk of death or serious bodily harm and alternative procedures unless you request not to know these risks. The type of anesthetic drug or technique will be chosen after discussion between you and your anesthesiologist. However, during the course of surgery, the anesthetic method may have to be changed.

Do you wish to discuss anesthesia with the anesthesiologist? **Yes** ☐ **No** ☐

I am aware that there are serious risks with EVERY anesthetic.

I do not require any additional information about my anesthesia.

I give my consent for the provision of anesthesia.

Signature of patient or parent____

Witness signature____________________________Date____________________

Reviewed by Anesthesiologist____

ANESTHESIA HEALTH INFORMATION

To help your doctors and nurses provide the best possible care, please fill out this pre-operative health form. Please answer all questions and fill in all blanks. This information will be reviewed with you prior to surgery.

Operation that is planned (in your own words)____

Medications you take regularly____

Medicines to which you are allergic____

Previous operations (include year)____

____

Previous serious illness (include year)____

Your current weight________Lbs. Your current height_______________

Time you last ate or drank anything____

1.	Have you ever had a problem with anesthesia or surgery?	Yes ☐	No ☐	________________
2.	Has any blood relative had a problem with anesthesia?	Yes ☐	No ☐	________________
3.	Have you ever smoked? #of packs per day?	Yes ☐	No ☐	________________
4.	Do you have a cough or cold?	Yes ☐	No ☐	________________
5.	Have you ever had asthma?	Yes ☐	No ☐	________________
6.	Have you had bronchitis, pneumonia, or abnormal chest X-ray?	Yes ☐	No ☐	________________
7.	Do you get shortness of breath walking up two flights of stairs?	Yes ☐	No ☐	________________
8.	Have you any difficulty breathing?	Yes ☐	No ☐	________________
9.	Have you ever had high blood pressure?	Yes ☐	No ☐	________________
10.	Do you have discomfort or pain in your chest?	Yes ☐	No ☐	________________
11.	Have you ever had a heart attack?	Yes ☐	No ☐	________________
12.	Have you ever had an irregular heart beat?	Yes ☐	No ☐	________________
13.	Have you ever had an abnormal electrocardiogram (ECG)?	Yes ☐	No ☐	________________
14.	Have you ever had a heart murmur?	Yes ☐	No ☐	________________
15.	Do you drink alcohol? How much?	Yes ☐	No ☐	________________
16.	Have you ever had yellow jaundice or hepatitis?	Yes ☐	No ☐	________________
17.	Have you had any recent exposure to contagious diseases?	Yes ☐	No ☐	________________
18.	Have you ever given yourself intravenous drugs?	Yes ☐	No ☐	________________
19.	Have you had possible exposure to AIDS?	Yes ☐	No ☐	________________
20.	Have you ever had a stroke?	Yes ☐	No ☐	________________
21.	Do you have numbness or weakness in an arm or leg?	Yes ☐	No ☐	________________
22.	Have you ever had epilepsy, seizures, or black-out spells?	Yes ☐	No ☐	________________

#	Question	Yes	No	
23.	Do you have frequent headaches?	Yes ☐	No ☐	________________
24.	Do you have back problems?	Yes ☐	No ☐	________________
25.	Have you ever had kidney disease?	Yes ☐	No ☐	________________
26.	Do you have diabetes?	Yes ☐	No ☐	________________
27.	Do you have a goiter or thyroid disease?	Yes ☐	No ☐	________________
28.	Do you have arthritis?	Yes ☐	No ☐	________________
29.	Do you have problems opening your mouth/moving your neck?	Yes ☐	No ☐	________________
30.	Have you ever had broken bones of face, neck, or back?	Yes ☐	No ☐	________________
31.	Have you ever had glaucoma or other eye problems?	Yes ☐	No ☐	________________
32.	Have you had an ulcer, hiatal hernia or heartburn?	Yes ☐	No ☐	________________
33.	Do you have loose teeth, dentures, or caps on your teeth?	Yes ☐	No ☐	________________
34.	Do you have any bleeding tendencies?	Yes ☐	No ☐	________________
35.	**(Female patients)** Could you be pregnant?	Yes ☐	No ☐	________________
36.	Any other health problems?______________________________			

List subjects (numbers) you wish to discuss with the Anesthesiologist____________________________________

To the best of my knowledge, the above information is accurate.

Patient's Signature: ____________________________________ **Date** ________________________

Reviewed by Anesthesiologist____________________________**Date**__________________________