Ambulatory Surgery Center of Western New York
945 Sweet Home Road, Amherst, NY 14226

SELF REPORTING HEALTH HISTORY

FORM TO BE COMPLETED BY PATIENTS OVER THE AGE OF 18 HAVING ANESTHESIA

PLEASE PRINT Patient Name_____
Patient Address_____
Patient Phone#_____Emergency Contact/ Phone #_____
Patient DOB_____

PRIMARY CARE PHYSICIAN NAME_____
ADDRESS OF PRIMARY PHYSICIAN_____
PHONE NUMBER OF PRIMARY PHYSICIAN_____
Height_____ Weight_____
Race Caucasian African American Hispanic Asian Native American

Allergies: List all drug allergies

Drug	**Reaction**
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

Other types of allergies:

** **Latex allergy**** **Yes** **No**

Food or Material	**Reaction**
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

Are you hearing impaired? No Yes (Explain)_____
Do you have bleeding problems? No Yes (Explain)_____
Are you currently taking blood thinners No Yes (Explain)_____
Do you have problems breathing through your nose? No Yes (Explain)_____
Do you have limited range of motion within any joints (jaw)? No Yes (Explain)_____
Smoking: No Yes Cigarettes Per Day____No. of yrs.____
If you quit-when_____
Do you drink alcohol? No Yes Amounts_____ No. of Years_____
Recreational drugs No Yes
History of Malignant Hyperthermia (Family Members): No Yes
(HIGH FEVERS FOLLOWING ANESTHESIA)
Describe_____

Check any condition that applies to you and explain briefly:

Anemia	**No**	**Yes**	**_____**	**Mental Illness**	**No**	**Yes**	**_____**
High blood Pressure	**No**	**Yes**	**_____**	**Stroke/Weakness Arm/Leg**	**No**	**Yes**	**_____**
Chest Pain/Angina	**No**	**Yes**	**_____**	**Heart Attack or Failure**	**No**	**Yes**	**_____**
Diabetes	**No**	**Yes**	**_____**	**Hepatitis/Jaundice/Cirrhosis**	**No**	**Yes**	**_____**
Rheumatic Fever	**No**	**Yes**	**_____**	**Kidney/Urinary/Problems**	**No**	**Yes**	**_____**
Mitral Valve Prolapse	**No**	**Yes**	**_____**	**Stomach Prob/Hiatal Hernia**	**No**	**Yes**	**_____**
Irregular Heart Beat	**No**	**Yes**	**_____**	**Bronchitis**	**No**	**Yes**	**_____**
Other Heart Disease	**No**	**Yes**	**_____**	**Asthma**	**No**	**Yes**	**_____**
Thyroid Disease	**No**	**Yes**	**_____**	**Emphysema**	**No**	**Yes**	**_____**
Motion Sickness	**No**	**Yes**	**_____**	**Seizures/Epilepsy**	**No**	**Yes**	**_____**
Tuberculosis	**No**	**Yes**	**_____**	**Paralysis**	**No**	**Yes**	**_____**
Shortness of Breath:	**No**	**Yes**	**_____**	**Back Problems**	**No**	**Yes**	**_____**
During Rest	**No**	**Yes**	**_____**	**Black Out Spells**	**No**	**Yes**	**_____**
During Mild Exercise	**No**	**Yes**	**_____**	**Blood Thinners**	**No**	**Yes**	**_____**
Cough	**No**	**Yes**	**_____**	**FEMALES ONLY:**			
Do you currently have				**Possibility of Pregnancy**	**No**	**Yes**	**_____**
a cold?	**No**	**Yes**	**_____**	**Date of Last Period_____**			

Other Medical Conditions_____

Body Piercings **No** **Yes** **_____**

If yes, Where?_____

CURRENT MEDICATIONS/OVER THE COUNTER VITAMINS & DOSAGES

MEDICATIONS	DOSAGES	FREQUENCY	LAST TIME TAKEN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HAVE YOU HAD ANY OPERATIONS IN THE PAST? NO YES PLEASE LIST

OPERATION	**DATE**	**OPERATION**	**DATE**