SLEEP EASY ANESTHESIA

Patient Health Questionnaire:

Date: ____/____/_____

Patient Name:_________________________________ D.O.B. _____/_____/_____

Please answer all questions to the best of your knowledge. All information provided will remain confidential.

Are you in good health? **Yes No**

Age___________Height__________Weight___________

Are you now under the care of a physician? **Yes No**

Name and address of your physician:____

Has there been any change to your general health? **Yes No**

Have you ever had a serious illness or operation? **Yes No**

If yes, please list below:

Have you been hospitalized in the past 5 years? **Yes No**

If yes, please list for what reason:

Do you have any medication, food, or environmental allergies? **Yes No**

If yes, please list below:

Have you or a family member experienced any problems with anesthesia **Yes No**

Do you take any medications or herbal supplements? **Yes No**

If yes, please list below:

Do you smoke? **Yes No**

If yes, how much?____________

Do you drink alcohol? **Yes No**

If yes, how much?____________

Do you use recreational drugs? **Yes No**

If yes, please list:

Do you have, or have you had, any of the following diseases or problems?

- Rheumatic fever or heart disease? **Yes No**
- Heart murmur, congenital heart lesion, or valvular disease? **Yes No**
- Cardiovascular disease? If yes, please answer below: **Yes No**
  - Do you have chest pain on exertion? **Yes No**
  - Are you ever short of breath after mild exercise? **Yes No**
  - Do you sleep with extra pillows at night? **Yes No**
- COPD? **Yes No**
  - Do you use oxygen at home? **Yes No**
- Sleep Apnea? **Yes No**
  - Do you use a CPAP machine at night? **Yes No**
- Asthma? **Yes No**
- Seizures? **Yes No**
- Stroke? **Yes No**
- Diabetes? **Yes No**
- Arthritis? **Yes No**
- Stomach ulcers? **Yes No**
- Thyroid disease? **Yes No**
- Kidney disease? **Yes No**
- Hepatitis, jaundice, or liver disease? **Yes No**
- Radiation or chemotherapy? **Yes No**
- Immunosuppresion? (Possibly from transplant surgery) **Yes No**
- Bleeding tendency or abnormal bleeding/bruising? **Yes No**

For Women Only

Are you pregnant or could you be? **Yes No**

Are you nursing? **Yes No**

Are you taking oral contraceptives? **Yes No**

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist and anesthesia provider before my next visit.

Patient/Guardian Signature:________________Date:__/__/___ Anesthetist Signature:______________Date:__/__/___

Contact Information: (phone)__________________ (email)_______________________________________