

SAN ANTONIO REGIONAL HOSPITAL
999 San Bernardino Road, Upland, California 91786

MEDICAL INFORMATION QUESTIONNAIRE

Please circle all medical conditions you currently or have ever suffered from. Questions related to the medical conditions are to be directed to the attending anesthesiologist/MD. Please disregard the information typed in red, it is for office use only. Thank you.

HEART

Recent Chest Pain (EKG)
Heart Attack (EKG/CXR/Cardio Consult)
Heart Murmur
Valve Disease or Replacement (EKG)
High Blood Pressure (>50yrs./>160/100 -EKG)
Irregular Heart Beat
Palpitations
Ankle Swelling
Recent Chest Trauma
Bypass/Angioplasty/Transplant
AICD Implant
Pacemaker

LUNGS (O2sat-<95% on RA-CXR)

Recent cold or Flu/Cough
Need to Sleep on 2-3 Pillows
Difficult to Breathe (CXR)
History of Smoking ____ Packs Per Day (>50yrs. old-CXR)
Asthma
Chronic Lung Disease (CXR)
Emphysema (CXR)
Bronchitis
Tuberculosis Treated/Untreated (CXR)
Sleep Apnea
Have Had Sleep Study
Uses C-Pap or BiPap - Bring Machine

DIGESTIVE

Loose Teeth / Dentures / Partials
Heartburn / Antacid Usage
Hiatal Hernia / Reflux
Ulcers
Hepatitis / Jaundice / Cirrhosis / Liver Disease (SGOT/PT/PTT)
Recent Nausea / Vomiting
Recent Diarrhea / Abdominal Pain
Rectal Bleeding

NERVOUS SYSTEM

Loss of Consciousness
Seizures (If taking Phendorbital, Tegretol, Dilantin, or Depakote draw levels the day of surgery)

NERVOUS SYSTEM, cont.

Stroke
Paralysis
Numbness / Weakness
Brain Tumor / Aneurysm

RENAL (K+ / BUN / CR)

Kidney Disease
Dialysis
Blood or Protein in Urine
Transplant

VASCULAR

Lupus
Poor Circulation
Raynauds
Aneurysm

ENDOCRINE

Thyroid Problems
Steriod/Prednisone Use
Adrenal Problems (BS)
Diabetes (BS)
Ketoacidosis
Insulin Pump (Notify DTC)

BLOOD (CBC)

Anemia
Leukemia
Polycythemia
Sickle Cell
Bruise Easy
Ever had a transfusion

ORTHOPEDIC

Stiff or Painful Neck
Neck Fusion
Spinabifida
Jaw Pain
TMJ Syndrome
Scoliosis
Arthritis
Disc Disease / Surgery
Implant _____ Date _____

(Continued on Back)



SA000036

#2754 (Rev. 6/09) mm

**Assignment of Insurance Benefits and
Acknowledgement of Financial Responsibility**

Patient Name: _____
Attention: _____
Address: _____

I hereby authorize release of information necessary to file a claim with my insurance carrier and assign benefits otherwise payable to me. I acknowledge that I am individually responsible to pay Upland Anesthesia Medical Group the amount billed for any services rendered upon receipt of billing. I further acknowledge that, while Upland Anesthesia Medical Group may elect to seek reimbursement for services rendered from my insurance carrier, I remain primarily responsible for payment.

ANESTHESIA

Previous Anesthesia Difficulties
Family History of Difficulty with Anesthesia
Malignant Hyperthermia/High Fever
Severe Nausea
Difficulty Breathing Upon
Awakening from Anesthesia
History of Radiation to Head or Neck
Pseudocholinesterase Deficiency

OTHER

Spiritual / Cultural Needs
Immunizations Current
Height: _____ Weight: _____

ALLERGIES (medication or food)

Allergies	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PEDIATRICS (<13 years)

Normal Growth and Development
Loose Teeth
NICU at Birth
Frequent Fevers/Infections
Prior Hospitalization
Days Hospitalized at Birth
Immunizations Current

PAIN MANAGEMENT:

Do you suffer from chronic pain? Explain _____
What previously used methods managed your pain? _____

PREVIOUS ILLNESS/SURGERY _____

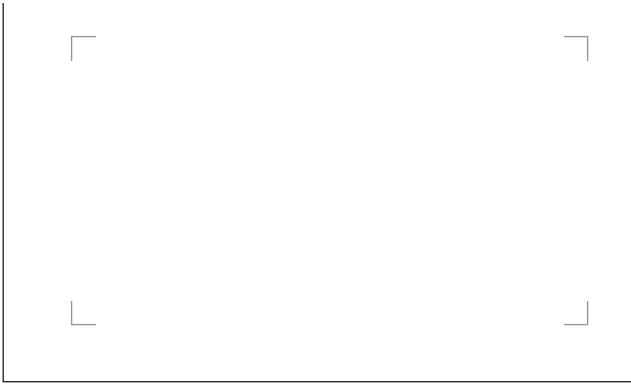
MEDICATIONS List all medications presently taking on the attached Medication Reconciliation Record.
(Diuretics K+/BUN/CR) (Digoxin-Dig Level)

Any other information we should have? _____

Patient's Signature

Date

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GYN (Females only) Circle or respond to all applicable.

Date of last menstrual cycle _____ (HCG)
Menopause
Hysterectomy
Tubal Ligation
Currently Pregnant

Preeclampsia
Gestational Diabetes
Placenta Abruptio or Detachment
Pregnancy Induced Hypertension or Toxemia
Twins/Breech Deliver

CANCER/TUMORS (CBC)

Radiation
Chemotherapy

INFECTIOUS DISEASE

MRSA
VRE

SKIN

Rash
Shingles
Scabies