Copper Queen Community Hospital Dr. Suzanne Daly
10524 E. Highway 92 Palominas, AZ 85615
Phone: (520) 335-6730 Fax: (520) 335-6855

Name: _____ Date of Birth: _____ Sex: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Address: _____City/State/Zip: _____

SSN: _____Marital Status: □ Married □ Single □ Widowed □ Divorced □ Other

Email: _____ Can we contact you via email with results? □ Yes □ No

Employed by: _____ How Long? _____Occupation: _____
Spouse's Name: _____ How Long? _____ Occupation:_____

Emergency Contact: _____ Phone#: _____

**Please list any person(s) we are allowed to speak with regarding your medical information:**

_____

_____

Primary Care Physician: _____
Address: _____ City/State/Zip: _____

Phone#: _____ Fax#: _____

Referred by: _____

## Insurance:

Primary Insurance: _____ Policy#: _____ Group#:_____

Name of Insured: _____ DOB: _____ SSN: _____
Relationship to patient:_____

Secondary Insurance: _____ Policy#: _____ Group#: _____
Name of Insured: _____DOB: _____ SSN: _____

Relationship to patient: _____

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Name_____DOB:_____Date_____

Briefly state the reason you are here: _____
Are you allergic to any medications? ___None ___Yes, please list below
_____
_____
Are you allergic to: ___Milk ___Soy ___Eggs ___ None
Do you drink alcohol: ___No ___Yes, How much? _____ Quit? When: _____
Do you smoke: ___Never ___Yes, How much? _____ Former Smoker Quit when? _____
Recreational Drugs ___No ___Yes, please list _____

**Please list all medications (prescription or over the counter, vitamins, or herbs that you are currently taking) including dosage and frequency**

| Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Previous Surgical History (Please include year)**
Gallbladder/Cholecystectomy_____ Hysterectomy_____ Appendix/Appendectomy _____
Heart Surgery (type) _____ Colon/Bowel _____ Other _____
Past Medical History (Please check all that apply)
___Prior Colonoscopy: When _____ Findings: Colon Polyps___ Colon Cancer___ Other_____
___Prior Upper Endoscopy: When _____ Findings: IBS___ Ulcers (where?) _____ Other_____
___Liver Disease (what kind) _____ Cancer of: _____ Crohn's disease____
___Rash Where? _____ Heartburn___ Ulcerative Colitis___ Diverticular Disease___ Mouth Sores___
___High Blood Pressure Anemia___ Yellow skin/eyes (jaundice) ___ Diabetes___ Arthritis___
___Thyroid Disease: Hypo or__ Hyper___ Kidney Disease _____
Swollen ankles/feet___ Other: _____

**Mark all that apply:**

| **Heart Problems** | **Yes** | **No** | | **Lung Problems** | **Yes** | **No** |
|---|---|---|---|---|---|---|
| Chest pain/angina | ____ | ____ | How often_____ | Asthma/wheezing | ____ | ____ |
| Heart failure | ____ | ____ | When | Emphysema/COPD | ____ | ____ |
| Afib/Pacemaker | ____ | ____ | | CPAP/O2 | ____ | ____ |
| Arrhythmias | _____ | ____ | | Shortness of breath | ____ | ____ |

**Name**: _____ **DOB**: _____

Low blood sugar: Yes _____No _____
Seizure/convulsions: Yes _____No _____ Nerve Damage: Yes _____ No _____
Paralysis: Yes _____ No _____ Stroke: Yes _____ No _____
Anxiety/Depression: Yes _____ No _____ Stress Level? Low ____ Moderate ____ High ____

**Please make any recent digestive symptoms that apply:**
__Abdominal Pain __Heartburn __Acid Reflux __Nausea __Vomiting __Change in bowl habits
__Diarrhea __Constipation __Blood in stool __Rectal bleeding __Weight gain ____lbs
__Weight loss ____lbs __Hemorrhoids __ Internal __ External __Trouble swallowing

**Family History: Mark here if unknown ____**
Father: Alive ___ Age ___ Deceased ___ Age ___ Cause of Death _____
Mother: Alive ___ Age ___ Deceased ___ Age ___ Cause of Death _____

| Family Health History | Maternal/Relationship to patient | Paternal/Relationship to patient |
|---|---|---|
| Colon Polyps | | |
| Ulcerative Colitis | | |
| Liver Disease | | |
| Diabetes | | |
| Colon Cancer | | |
| Gastric Cancer | | |
| Gallstones | | |
| Crohn's | | |
| IBS<br>What Kind? | | |
| Pancreatitis | | |
| Ovarian/Endometrial Cancer | | |
| Other Cancer<br>What Kind? | | |

**Social History**
Marital Status:
__Single __Married __Divorced __Widowed __Domestic Partnership

Occupation: _____ Number of Children: _____

Pharmacy: _____

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# Pre-Anesthesia Testing Questionnaire

**This form is to provide the safest care possible, these questions are required by our Anesthesia Department. Please take a moment and complete as accurately as you can. Thank you for letting us care for you!**

| Patient Name | Date of Birth | Age | Height | Weight |
|---|---|---|---|---|
| | | | | |

| Proposed Surgery | Medication Allergies (Please list): | Egg Allergy<br>**YES NO** |
|---|---|---|
| | | |

List all medication/supplements/over the counter pills you take: _____

_____

| | NO | Yes and how much |
|---|---|---|
| Do you drink alcohol? | | |
| Do you smoke? | | |
| Do you use recreational drugs? | | |

List all surgeries that you have had: _____

_____

| Have you ever had? | NO | Yes, please provide more details |
|---|---|---|
| Chest Pain/Angina | | |
| Heart Attack | | |
| Heart Failure | | |
| A.Fib/Pacemaker | | |
| Arrhythmias/Defibrillator | | |
| Stents | | |
| Leg Pain/Clotting | | |
| Heart Surgery | | |
| High Blood Pressure | | |
| Asthma | | |
| Emphysema/COPD | | |
| Recent Pneumonia | | |
| Liver Disease | | |
| Hepatitis | | |
| Kidney Disease (Not Stones) | | |
| Dialysis | | |
| Renal Failure | | |
| Diabetes | | |
| Low Blood Sugar | | |
| Seizure/Convulsions | | |

| | | |
|---|---|---|
| Nerve Damage | | |
| Paralysis | | |
| Stroke | | |
| Anemia | | |
| Steroid use more than 6 months? | | |
| Dou you have an infection now? | | |
| Serious Staph/MRSA Infection? | | |

| | YES | NO |
|---|---|---|
| Have you ever had issues with Anesthesia? | | |
| Have you ever been told you are difficult to intubate? | | |
| Have any family members had other problems with anesthesia? | | |
| Have you had a high fever with anesthesia? (Malignant Hyperthermia) | | |
| Has any close family member had high fever with Anesthesia? (Malignant Hyperthermia) | | |

_____ _____

Signature of person completing form Date