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PATIENT NAME: ____

DATE OF BIRTH: __________________ **TODAY'S DATE:** _______________

1. Do you have any breathing problems such as Sleep Apnea, Asthma, COPD? If so are you on oxygen?

2. Do you have a heart condition, heart valve disease or had heart valve surgery?

3. Do you see a heart or lung doctor and if so who?

4. Do you have a pacemaker or a defibrillator?
   Who monitors this?

5. Do you take a blood thinner?
   If so, please circle: Coumadin, Xarelto, Pradaxa, Aspirin, Effient, Brilinta, Eliquis, Plavix .

6. Do you have any history of heart stents within the last year?
   When was your last stress test?

7. Have you ever been told that your anesthesiologist or other doctor had a difficult time placing a breathing tube (intubation) during a surgery?

   Have you ever had problems with anesthesia or a history of malignant hyperthermia?

   Any family history of problems with anesthesia or a history of malignant hyperthermia?

8. Do you have any neck problems?
   Have you ever had plates or screws put in your neck or had a neck fusion?

9. Do you take a weight loss medication? Phentermine?

10. Have you ever had an infectious disease such as Hepatitis, Tuberculosis, VRE, MRSA, C-Diff?

11. Have you ever had a stroke, seizure, or any other neurological disorder?

12. Do you have diabetes? Do you take pills or Insulin?

13. Do you have a latex allergy?