

**LONG BEACH MEMORIAL MEDICAL CENTER  
MILLER CHILDREN'S HOSPITAL; WOMEN'S HOSPITAL  
ANESTHESIA CONSENT AND INFORMATION FORM**

**ANESTHESIA CONSENT**

Modern anesthesia carries risks minimal enough that virtually everyone can be offered its benefits. However, every type of pain relief (anesthesia) has a certain risk which is known by your doctors. In most cases these risks are minimal. California law requires that doctors must inform you of the risk of death or serious bodily harm and alternative procedures unless you request not to know these risks. The type of anesthetic drug or technique will be chosen after discussion between you and your anesthesiologist. However, during the course of surgery, the anesthetic method may have to be changed.

**Do you wish to discuss anesthesia risks with the anesthesiologist?      YES / NO  
(circle)**

**I am aware that there are serious risks with EVERY anesthetic.  
I do not require any additional information about my anesthesia.  
I give my consent for the provision of anesthesia.**

**Signature of patient or parent** \_\_\_\_\_

**Witness signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Reviewed by Anesthesiologist** \_\_\_\_\_

**HEALTH INFORMATION**

To help your doctors and nurses provide the best possible care, please fill out this pre-operative health form. Please answer all questions and fill in all blanks. This information will be reviewed with you prior to surgery.

Operation that is planned \_\_\_\_\_

Medications you take regularly \_\_\_\_\_

Medicines to which you are allergic \_\_\_\_\_

Previous operations (include year) \_\_\_\_\_

Previous serious illnesses (year) \_\_\_\_\_

Your current weight \_\_\_\_\_ Lbs.      Your current height \_\_\_\_\_

**Time you last ate or drank anything** \_\_\_\_\_

***Please fill out the other side of this form.***

# HEALTH INFORMATION

	Circle YES or NO	Comments
01-Have you ever had a problem with anesthesia or surgery? . . . . .	YES NO	_____
02-Has any blood relative had a problem with anesthesia? . . . . .	YES NO	_____
03-Have you ever smoked? # of packs/day? _____ . . . . .	YES NO	_____
04-Do you have a cough or cold . . . . .	YES NO	_____
05-Have you ever had asthma? . . . . .	YES NO	_____
06-Have you had bronchitis, pneumonia, or abnormal chest X-ray? . . . . .	YES NO	_____
07-Do you get short of breath walking up two flights of stairs? . . . . .	YES NO	_____
08-Have you had any difficulty breathing? . . . . .	YES NO	_____
09-Have you ever had high blood pressure? . . . . .	YES NO	_____
10-Do you have discomfort or pain in your chest? . . . . .	YES NO	_____
11-Have you ever had a heart attack? . . . . .	YES NO	_____
12-Have you ever had an irregular heart beat? . . . . .	YES NO	_____
13-Have you ever had an abnormal electrocardiogram (ECG)? . . . . .	YES NO	_____
14-Have you ever had a heart murmur? . . . . .	YES NO	_____
15-Do you drink alcohol? How much? _____ . . . . .	YES NO	_____
16-Have you ever had yellow jaundice or hepatitis? . . . . .	YES NO	_____
17-Have you had any recent exposure to contagious diseases? . . . . .	YES NO	_____
18-Have you ever given yourself intravenous drugs? . . . . .	YES NO	_____
19-Have you had possible exposure to AIDS? . . . . .	YES NO	_____
20-Have you ever had a stroke? . . . . .	YES NO	_____
21-Do you have numbness or weakness in an arm or leg? . . . . .	YES NO	_____
22-Have you ever had epilepsy, seizures, or black-out spells? . . . . .	YES NO	_____
23-Do you have frequent headaches? . . . . .	YES NO	_____
24-Do you have back problems? . . . . .	YES NO	_____
25-Have you ever had kidney disease? . . . . .	YES NO	_____
26-Do you have diabetes? . . . . .	YES NO	_____
27-Do you have a goiter or thyroid disease? . . . . .	YES NO	_____
28-Do you have arthritis? . . . . .	YES NO	_____
29-Do you have problems opening your mouth/moving your neck? . . . . .	YES NO	_____
30-Have you ever had broken bones of the face, neck, or back? . . . . .	YES NO	_____
31-Have you ever had glaucoma or other eye problems? . . . . .	YES NO	_____
32-Have you had an ulcer, hiatal hernia or heartburn? . . . . .	YES NO	_____
33-Do you have loose teeth, dentures, or caps on your teeth? . . . . .	YES NO	_____
34-Do you have any bleeding tendencies? . . . . .	YES NO	_____
35-Could you be pregnant? . . . . .	YES NO	_____
36-Any other health problems? _____ . . . . .	YES NO	_____

List subjects (numbers) you wish to discuss with the Anesthesiologist \_\_\_\_\_

**To the best of my knowledge, the above information is accurate**

**Signature of patient or parent** \_\_\_\_\_

**Reviewed by Anesthesiologist** \_\_\_\_\_ **Date** \_\_\_\_\_