Anesthesia Questionnaire and Consent to Treatment

HAVE YOU HAD OR CURRENTLY HAVE:

	YES	NO		YES	NO
Problems with Anesthesia			**Tuberculosis**		
High Fevers after Anesthesia			**Bronchitis, Asthma, Emphysema**		
Loose Teeth/ Dentures			**Shortness of Breath**		
Glasses/ Contact Lenses			**Oxygen Dependent** **If YES, how much?** **___day & night ___ night only**		
Aneurysms			**Hiatal Hernia/ Nausea/ Heartburn**		
Seizures			**Diabetes**		
Black Outs (syncope)			**Thyroid Trouble**		
High Blood Pressure (even if controlled)			**Blood Clotting Problems**		
Heart Problems:			**History of Bleeding/ Anemia**		
Heart Attack			**Sickle Cell Disease**		
Chest pain			**Any Neck or Back Problems**		
Irregular Heartbeat/ Palpitations			**Are you Pregnant now**		
Heart Failure			**Kidney Trouble**		
Heart Surgery			**Are you on Dialysis**		
Heart Valve Problems			**Autoimmune Disease: Lupus or Rheumatoid Arthritis or other: ___**		
Heart Stents? If yes, Date:			**History of Alcohol or Drug Abuse**		
Do you have a Pacemaker			**History of Anxiety or Depression**		
Pacemaker with Defibrillator **Brand: _____**			**Do you drink Alcohol? (if yes how much?)** **____day ____week _____month** **____year**		
Cardiac Cath in the last 18 months			**Any Problems with Sleep Apnea**		
Echocardiogram in the last 18 months			**Do you smoke/ ever smoked**		
Stress Test in the last 18 months			**Height: _____ Weight: _____**		

Drug/ Latex/ Tape Allergies: _____

Current medication: _____

Prior Surgeries: _____

Pharmacy: _____ **Primary Care Provider** _____

Email: _____ Race: _____ Ethnicity: _____

Emergency Contact: _____ **Phone** _____ **Relationship:** _____

Current Insurance: Primary: _____ _____ **Secondary:** _____ _____

I certify that the information above is true and accurate, that I have coverage with the above insurance(s) and assign directly to Gastroenterology & Nutrition of Central Florida all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the disclosure of my health care information in order to obtain payment of insurance benefit information from the above named insurance company (-ies).

I hereby authorize and consent for medical treatment provided by Gastroenterology & Nutrition of Central Florida. I understand that the physical examination may include a medically appropriate examination of my pelvic area, and/or rectum and I consent to such examination.

Patient Name: _____ **Patient Signature:** _____ _____ **Date:** _____

Social Security Number (last four digits): _____