Straith Clinic, a Forefront Practice
Health Questionnaire/Pre-Anesthesia Evaluation

Name: _____ D.O.B. _____ Age _____ ☐ Male ☐ Female

Phone Number: _____ Height _____ Weight: _____ BMI: _____ (for office use)

Family Doctor: _____ City: _____ Phone: ( ) _____

Emergency Contact: _____ Relation: _____ Phone: ( ) _____

Please check ✓ "yes" or "no"next to any condition you have been diagnosed with currently or in the past
Please complete as thoroughly as possible. Information that is withheld or incorrect could result in delay or cancellation of procedure.

Cardiac	Yes	No
Congestive Heart Failure (CHF)	☐	☐
Cardiomyopathy	☐	☐
Mitral Valve Prolapse	☐	☐
Congenital Heart Disease	☐	☐
Heart Attack	☐	☐
Coronary Artery Disease (CAD)	☐	☐
Atrial Fibrillation	☐	☐
Endocarditis / Rheumatic Fever	☐	☐
Stroke / TIA	☐	☐
Residual effects_____		
Pacemaker / AICD	☐	☐
Heart Surgery	☐	☐
Angina / Chest tightness with exercise	☐	☐
Heart Murmur	☐	☐
Irregular heart beat	☐	☐
Type_____		
High Blood Pressure	☐	☐
Average blood pressures	☐	☐
High Cholesterol (HLD)	☐	☐
Anemia	☐	☐
Bleeding disorders	☐	☐
Type_____		

Pulmonary	Yes	No
Lung Cancer	☐	☐
Pulmonary Fibrosis	☐	☐
Pulmonary Hypertension	☐	☐
Emphysema/ COPD	☐	☐
Pleural effusion	☐	☐
Pulmonary embolism	☐	☐
Recent cold/bronchitis/pneumonia	☐	☐
Productive Cough	☐	☐
Asthma	☐	☐
Controlled ☐ Uncontrolled ☐		
Shortness of breath at rest	☐	☐
Shortness of breath with exercise	☐	☐
Environmental Allergies	☐	☐
History of snoring	☐	☐
Obstructive Sleep Apnea	☐	☐
CPAP Use ☐ Yes ☐ No		
Smoking / Vaping	☐	☐
Date Started _____ Date Stopped _____		
Other_____		

Endocrine/ GI / Renal	Yes	No
Liver disease / Jaundice	☐	☐
Cirrhosis / Hepatitis(A B C)	☐	☐
Pancreatitis	☐	☐
Chronic Kidney Failure	☐	☐
Dialysis	☐	☐
Stomach Ulcer	☐	☐
IBS / Ulcerative Colitis	☐	☐
Weight Loss Surgery date:	☐	☐
Diabetes	☐	☐
Type I ☐ Type II ☐		
Thyroid disease (High or Low)	☐	☐
Pituitary Disorder	☐	☐
Kidney Stones	☐	☐
Chronic UTI	☐	☐
GERD/ Heartburn	☐	☐
Controlled ☐ Uncontrolled ☐		
Autoimmune disorder	☐	☐
Name of disorder_____		
History of motion sickness	☐	☐
Other _____		

Neurological/Musculoskeletal	Yes	No
Epilepsy / Seizures	☐	☐
Date of last seizure _____		
Multiple Sclerosis	☐	☐
Chronic pain	☐	☐
Location _____	☐	☐
Stroke / TIA	☐	☐
Head Injury / TBI	☐	☐
Parkinson's Disease	☐	☐
Migraines / chronic headache	☐	☐
ADD/ ADHD	☐	☐
Depression / Anxiety	☐	☐
Mood Disorder	☐	☐
	☐	☐

Vascular / Other	Yes	No
Cancer	☐	☐
Location _____ Date_____	☐	☐
Chemo / Radiation	☐	☐
Aneurysm	☐	☐
Type _____		
HIV / AIDS	☐	☐
Sickle cell disease or trait	☐	☐
History of blood clots	☐	☐
Peripheral vascular disease	☐	☐
Chronic fatigue	☐	☐
History of blood transfusion	☐	☐
Arthritis	☐	☐
Osteopenia	☐	☐

Social / Functional	Yes	No
Consume alcohol	☐	☐
Drinks per week _____		
Marijuana Use	☐	☐
Drug Use	☐	☐
Type _____ Last used _____		
Body piercings	☐	☐
Dentures/ bridges	☐	☐
Wear glasses or contacts	☐	☐
Difficulty speaking / swallowing	☐	☐
Difficulty walking	☐	☐
Hard of hearing	☐	☐
Chance of pregnancy	☐	☐
Date of last menstrual period	☐	☐
_____		

Have you had	Yes	No	If yes, when/ Doctor's name/ Results
Heart Catheterizaion	☐	☐	_____
Ultrasound of the heart	☐	☐	_____
Exercise Stress Test	☐	☐	_____

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Health Questionnaire/Pre-Anesthesia Evaluation

Name:_____ D.O.B. _____

Please list all previous surgeries and hospitalizations (including childbirth)

Date (month/year)	Reason	Place (hospital or city)

Anesthesia/ Surgical Assessment

	Yes	No
Problems with anesthesia Please explain_____	☐	☐
Family history of problems with anesthesia Please explain_____	☐	☐
Nausea &/or vomiting after anesthesia Please explain_____	☐	☐
Problems with previous surgery Please explain_____	☐	☐

Medications

Include all prescriptions, non-prescription, vitamins & supplements currently in use

Name	Dose	Frequency

Allergies

	Yes	No	Reaction
Latex	☐	☐	
Food	☐	☐	
Adhesive / Tape	☐	☐	
Iodine on your skin	☐	☐	

Medications

Please list	Reaction

****Are you taking or plan to take any semiglutides or GLP1's (Ex:Mounjara, Ozempic, Zepbound or Trulicity etc.) YES or NO ****

Other than Surgical services please check below any of our Med Spa services that you would like to learn about or have concerns about

☐ Botox	☐ Microneedling	☐ Facial redness	☐ Other Concerns or Comments:
☐ Fillers	☐ Laser Treatments	☐ Brown spots/age spots/freckle	_____
☐ Skin Care Advice	☐ Facial fine lines/wrinkles	☐ Drooping Brow	_____
☐ Skin Care Products	☐ Thin Lips	☐ Drooping eyelids	_____
☐ Chemical Peel	☐ Facial Veins	☐ Neck wrinkles	_____

_____ _____
Signature of patient or gaurdian Date

For Office Use

REVIEWED BY: UPDATED:

_____ _____ _____ _____

NOTES:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

	CL	ANES
HQ REC'D		
H & P REC'D		
HQ SENT TO ANES		

ADDITIONAL TESTING / INFO REQUESTED

_____ _____
_____ _____

LAB / TEST RESULTS