

Dear Patient: The Anesthesia staff at The Reading Hospital welcomes the opportunity to assist with your care. Please provide us with the following health information. Decisions regarding your care will be made from this information. Check the appropriate box listed next to the health issue, if you do or did have any health issues listed on this form. (Please use black ink if possible.)

**For Example:** If you have High Blood Pressure, check that box in the Circulation section.

<b>CIRCULATION</b>	<input checked="" type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Clots	<input type="checkbox"/> Other	<b>NONE</b>
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If you have no health issues involving circulation ,check **NONE**

<b>CIRCULATION</b>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Clots	<input type="checkbox"/> Other	<b>NONE</b> <input checked="" type="checkbox"/>
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**NOTE:** If you complete this form in your physician's office, the office will forward this form to the Pre-Admission Testing Center.

**If you did not complete this form in your physician's office, YOU MUST BRING THIS COMPLETED FORM TO THE PRE-ADMISSION TESTING CENTER AT THE TIME OF YOUR APPOINTMENT. Failure to do so may result in a delay on the day of pre-admission testing or a delay in your surgery.**

(Remove this sheet after reading instructions.)

You may also obtain a copy of this form and additional information about your anesthesia at [www.readinganesthesia.com](http://www.readinganesthesia.com)

