

Patient Label



Patient Name Date of Birth Age Sex Height Weight

Social Security # Home Phone Work Phone Cell Phone (optional)

Number where you can be reached night before surgery

Person to contact in an emergency (WHO DOES NOT LIVE WITH YOU) Relationship Phone Number

1.) List any allergies (i.e. drug, food, latex, tape) and explain reaction (rash, itching, swelling)

2.) Are you taking any type of diet pills or herbal medications? Yes No

3.) List all medications you are presently taking, including over the counter medications.

Table with 3 columns: Drug Name, Dosage, Frequency (times per day)

4.) Medical History: (please circle any that apply to you)

- heart, high blood pressure, chest pain, heart attack, heart murmur, heart failure, mitral valve prolapse, hypoglycemia, kidney problems, diabetic, apnea, asthma, bronchitis, emphysema, phlebitis, lupus, cancer, MS, neurological disorder, stroke, psychiatric disorders, depression, glaucoma, bleeding disorders, sickle cell disease, gastric ulcers, seizure disorder, back problems, arthritis, scoliosis, thyroid disease, birth defect, brain damage, cerebral palsy, intestinal disorders, hiatal hernia, fainting, seizures, migrane, hay fever, TB, hepatitis, dialysis, HIV/AIDS

5.) Have you had any recent respiratory infections, other type of infections or hospitalizations? Yes No If yes, please describe and list date:

6.) Do you have any of the following? (please circle any that apply to you)

pace maker	hip replacement	denture	hearing aid	use a cane
dialysis shunt	knee replacement	partial	contacts	use a walker
IV catheter	artificial limbs	braces/retainer	loose teeth	use a wheel chair
ostomy	amputee			

7.) List all previous surgeries:

<u>Approximate Year</u>	<u>Type of Surgery</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

8.) If female, date of last menstrual period: _____

9.) Have you, or any blood relative, ever had complications or reactions to anesthesia (delayed awakening, unexplained fever, MALIGNANT HYPERTHERMIA, vomiting, difficult intubation)?

Yes No If yes, please describe: _____

10.) Do you use:

alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: _____
tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: _____
caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: _____
recreational drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: _____

11.) Please list the name(s) of your current physician(s) (i.e. primary care physician, cardiologist, internist, pediatrician, orthopedist)

<u>Physician's Name</u>	<u>Specialty</u>	<u>Date of Last Visit</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that my health history was reviewed and update by me on:

_____ Today's Date	_____ Patient Signature	_____ Witness
_____ Today's Date	_____ Patient Signature	_____ Witness
_____ Today's Date	_____ Patient Signature	_____ Witness
_____ Today's Date	_____ Patient Signature	_____ Witness
_____ Today's Date	_____ Patient Signature	_____ Witness
_____ Today's Date	_____ Patient Signature	_____ Witness