MEDICAL HISTORY

Name:	DOB:	Height:	Weight:
Surgeon:	Surgery/Proc.	Primary MD:	

List all previous surgeries and procedures requiring sedation:

_____

_____

Metal implants/Locations: _____

Have you ever had anesthesia? _____ Have you ever had problems with anesthesia? _____ If yes, please comment:

_____

Have you or a relative ever been diagnosed with Malignant Hyperthermia? _____ Whom: _____

CARDIOVASCULAR

_____ High Blood Pressure
_____ Palpitations/Irreg. Heart Beat
_____ Mitral Valve Prolapse
_____ Heart Murmur
_____ Congestive Heart Failure
_____ Angioplasty/Stent- Date_____
_____ Pacemaker/Defibrillator
_____ Brand/Model of Device_____
_____ Coronary Artery Bypass Grafts
_____ Heart Attack – Year _____
_____ Angina/Chest Pain
_____ Coronary Artery Disease
_____ High Cholesterol
_____ Blood Clots
_____ Rheumatic Fever
_____ No Cardiovascular Problems

NEUROLOGICAL

_____ Seizures/Epilepsy
_____ Stroke/Paralysis
_____ Muscle Weakness/MS
_____ Parkinson's
_____ Mental Disorder
_____ Spinal Cord Abnormality
_____ Anxiety/Depression
_____ Other Neuro. Disease
_____ Migraines
_____ Head Trauma
_____ No Neurological Problems

MUSCULOSKELETAL

_____ Family History Muscle Disease
_____ Arthritis
_____ Back Problems
_____ No Musculoskeletal Problems

RESPIRATORY

_____ Cough/Cold last 2 weeks
_____ Asthma/Wheezing
_____ Emphysema
_____ Bronchitis
_____ Sleep Apnea____CPAP Use
_____ TB
_____ Allergies/Sinusitis(Hay fever)
_____ COPD
_____ Home O2 24 Hours
Liters of O2_____ Night only
_____ No Respiratory Problems

ENDOCRINE

_____ Diabetes Type 1 Type 2
_____ Thyroid Disease
_____ Other Endocrine Diseases
_____ Steroid Medication in past year
_____ No Endocrine Problems

ASSISTIVE DEVICES

_____ Dentures – Full Set
_____ Partial – Bridge
_____ Glasses/Contact Lenses
_____ Hearing Aids
Cane Crutches Wheelchair

OTHER

_____ **Last Menstrual Period**_____
_____ TMJ
_____ Special Diet: Type_____
_____ Glaucoma
_____ History of Staph Infection
_____ **Cancer** – Type_____
_____

GASTROINTESTINAL

_____ Ulcer
_____ Hiatal Hernia
_____ Acid Reflux/Heartburn
_____ Inflammatory Bowel Disease
_____ Hepatitis
_____ Difficulty Swallowing
_____ Other GI Disease
_____ No GI Problems

KIDNEY

_____ Kidney Failure
_____ Kidney Stones
_____ Frequent Urinary Infections
_____ Dialysis
_____ Other Kidney Disease
_____ No Kidney Problems

BLOOD

_____ Bleeding Disorder
_____ Sickle Cell
_____ Hemophilia
_____ Anemia
_____ Other Blood Disease
_____ Blood Thinners
_____ Blood Transfusion-Year_____
_____ No Blood Disorders

SOCIAL

_____ Have you ever smoked Yrs.____
Packs per day_____
Year Quit_____
_____ Drink Alcohol
Drinks per week_____
_____ Do you use medical marijuana
_____ Have you ever used street drugs
_____ HIV/AIDS

Name of Person Driving You Home After Your Surgery/Procedure _____ Phone _____.
(A responsible adult must accompany you to the center and remain until you are discharged.)
My surgeon **MAY MAY NOT** (please circle one) speak to my driver about findings of my surg./proc.
Phone number to reach me for follow-up after surg./proc. _____

Patient Signature: _____ Date: _____
Pre-OP Nurse Signature: _____ (verifies this form has been reviewed w/pt.)

MEDICATION RECONCILIATION FORM

List Medications and Foods to Which You are Allergic:

MED/FOOD	REACTION

Are you Allergic to Latex Products? Yes No Reaction_____

Home Medications Prescriptions, OTC, Vitamins, Herbs Name/Dosage/Frequency	**Last Taken** Date/Time	**Continue on Discharge** **(MD to Complete This Section)** Yes	No	Consult Primary MD

Medications Prescribed After Surgery/Procedure (to be taken as prescribed by your physician)

_____

_____

Signature of Patient: _____ **Signature of Pre-Op Nurse:** _____

Signature of PACU Nurse: _____

Signature of Physician: _____ **Date:**_____