

Pre-Operative Health History

Please mail or FAX BOTH SIDES of completed form to above address AS SOON AS POSSIBLE

Date of Surgery _____ Procedure: _____ Surgeon: _____

Name: _____ Phone: Home: _____ Cell: _____ Work: _____

Date of Birth: _____ Age: _____ Sex: Male Female Your Height: _____ Your Weight: _____

Primary Care Physician Name: _____ Doctors Phone: _____

Date and Location of most recent EKG (Males over 40 and Females over 50): _____

Have you ever had a Stress Test, Cardiac Work up, Echocardiogram or any other tests for you heart? No If YES LIST NAME OF TEST, DATE AND LOCATION: _____

Do you have a heart stent? No Yes Can you walk up one flight of stairs? No Yes

Are you allergic to EGGS? No Yes

Are you allergic to any medications? No If YES list all medication(s) you are allergic or sensitive to and the reactions:

Are you allergic to latex (rubber)? No If yes: Skin rash or swelling Respiratory (Wheezing)

Please list your current medications: No medications at this time

Are you taking insulin? No If YES, what name and dosage: _____

Do you have a **COUGH, COLD or FEVER** at this time? No Yes

Do you now have or have you ever had any of the following medical problems:

High blood pressure	Yes	No	Diabetes	Yes	No
Under good control?	Yes	No	Good Blood Sugar control (diabetics)	Yes	No
A heart attack	Yes	No	Hypoglycemia	Yes	No
Congestive heart failure	Yes	No	Neurological Disorders (weakness)	Yes	No
Heart murmur	Yes	No	Seizure Disorder	Yes	No
Chest pain or pressure	Yes	No	Stroke / TIA / Paralysis	Yes	No
Irregular heart beat	Yes	No	Kidney disease / Dialysis	Yes	No
Pacemaker / defibrillator	Yes	No	Bleeding problem	Yes	No
Heart valve replacement	Yes	No	Hepatitis / other liver disease	Yes	No
Sleep apnea	Yes	No	Severe arthritis	Yes	No
Do you have or use CPAP	Yes	No	Hypo or Hyperthyroid	Yes	No
Asthma / last attack _____	Yes	No	Tuberculosis / positive TB test	Yes	No
Emphysema / COPD	Yes	No	Psychiatric / emotional disorder	Yes	No
Home oxygen use	Yes	No	Cancer Site _____		
Heartburn or reflux	Yes	No	<input type="checkbox"/> Radiation <input type="checkbox"/> Chemo		
Good control?	Yes	No	Any Neck or back problems: _____		
Hiatal hernia	Yes	No	Other problems not listed above: _____		

Please explain on a separate page if needed.

If you have been tested for HIV: Negative Positive Never tested

Do you currently smoke cigarettes/cigars? No Yes If YES, how many per day_____

How often do you drink alcoholic beverages?_____ How many _____

Do you use recreational/street drugs? No Yes What drugs?_____ How often?_____

Do you have problems with balance, falling or need assistance with walking? No Yes

Do you use: walker cane wheel chair

Have you accidentally fallen in the past year? No Yes

List all previous surgeries: Never had surgery before

Do you have any concerns or special problems that we should be aware of? No Yes

If YES, please explain: _____

Have YOU or any BLOOD RELATIVE had any problems connected with anesthesia or operations, such as Malignant hyperthermia? No YES please specify including when, where and the type of reaction: _____

Have you been hospitalized for any reason in the past year: No Yes

If YES, please specify: _____

It is important that someone transport you and stay with you for 24 hours after your surgery.

Who is going drive and stay with you after your surgery?: _____

For Females: Date of your last menstrual period: _____ Are you pregnant or suspect that you might be? No Yes

Pediatric Patients need to bring current Immunization Record day of surgery, or have pediatrician fax it to us. 267-8256

Signature of patient or responsible party

Date

Relationship to patient (if not signed by patient)

DO NOT WRITE BELOW THIS LINE

Last Oral Intake:_____

Anesthesia Signature:_____

Patient History form Reviewed by: _____ Date: _____