Surgical Information Packet

Patient History

Your Full Name: ________________________________ **Date of Birth:** _______________

(First, Middle, Last)

Check all of the following conditions that you have or had:

☐ Anemia (low blood count)
☐ Asthma
☐ Bladder infection
☐ Cellulitis (skin infection)
☐ Coronary artery disease
☐ Diabetes
☐ Glaucoma
☐ CPAP/Sleep Apnea
☐ Hepatitis (liver disease)
☐ Kidney disease
☐ Leukemia
☐ Myocardial infarction (heart attack)
☐ Peptic ulcer disease
☐ SLE (lupus)
☐ Heart disease
☐ Angina (chest pain)
☐ Atrial fibrillation
☐ Bronchitis
☐ Congestive heart failure
☐ Deep venous thrombosis (blood clot)
☐ Fibromyalgia
☐ GERD (reflux)
☐ Hyperlipidemia (elevated cholesterol)
☐ High blood pressure
☐ Liver disease
☐ Migraine headache
☐ Osteoporosis
☐ Psoriasis
☐ Spinal stenosis
☐ CVA (stroke)
☐ Arthritis
☐ Benign prostatic hypertrophy (enlarged prostate)
☐ Cancer
☐ COPD (Chronic obstructive pulmonary disease)
☐ Depression
☐ Fractures
☐ Gout
☐ HIV/AIDS
☐ Lyme disease
☐ Multiple sclerosis
☐ Parkinson's
☐ Peripheral vascular disease
☐ Thyroid disease
☐ None

Have you or anyone in your immediate family ever had any problems with anesthesia?

☐ **No** ☐ **Yes**

*If so what happened?*____

____

Do you have any ALLERGIES to Medication? ☐ No☐ Yes

If so list:

____

____

____

ALLERGY to LATEX? ☐ No ☐ Yes

____

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List all medications, including prescriptions and samples below:

Medication Name	How often/dosage	Who prescribed?

Do you take over the counter drugs, vitamins, or supplements? ☐ No ☐ Yes

If so list: ____