

PATIENT NAME:	PREFERRED NAME:	PHONE #	AGE	HT.	WT.
REASON FOR ADMISSION/ NAME OF PROCEDURE	PROCEDURE DATE	DOCTOR	PRIMARY CARE PHYSICIAN		
ALLERGIES REACTION	<input type="checkbox"/> NONE <input type="checkbox"/> MEDICATIONS <input type="checkbox"/> FOODS <input type="checkbox"/> LATEX <input type="checkbox"/> OTHERS				
	<input type="checkbox"/> LIST				
PLEASE LIST ALL PREVIOUS HOSPITALIZATION(S) AND OPERATIONS (indicate approximate year)					
CHECK IF YOU HAVE HAD A BAD REACTION TO ANESTHESIA? <input type="checkbox"/> YES <input type="checkbox"/> NO					
HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA? <input type="checkbox"/> YES <input type="checkbox"/> NO					
YES NO HAVE YOU EVER HAD:			YES NO		

HEALTH HISTORY		DIABETES CONTROLLED BY <input type="checkbox"/> DIET <input type="checkbox"/> PILLS <input type="checkbox"/> INSULIN BLOOD SUGAR RESULTS		DO YOU HAVE A HISTORY OF SMOKING? PACKS PER DAY DATE QUIT
		HYPOGLYCEMIA (Low blood sugar)		DO YOU DRINK ALCOHOLIC BEVERAGES? HOW OFTEN HOW MUCH
		THYROID PROBLEMS		DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE OR ADDICTION?
		HEART PROBLEMS (Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Irregular Heartbeat, EKG changes, Angina, Valve Replacement, Pacemaker, Heart Failure, etc.)		DO YOU HAVE ANY OF THE FOLLOWING: <input type="checkbox"/> Jewelry Removed <input type="checkbox"/> False Teeth <input type="checkbox"/> Braces <input type="checkbox"/> Body Piercing <input type="checkbox"/> Loose Teeth <input type="checkbox"/> Retainers <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Bridges <input type="checkbox"/> Chipped Teeth <input type="checkbox"/> Capped Teeth <input type="checkbox"/> Contact Lenses
		BLOOD CLOTS, TRANSFUSION PROBLEMS, OR BLEEDING TENDENCY (Hemophilia, Anemia, Sickle Cell, etc.)		
		HIGH BLOOD PRESSURE		
		STROKE (Weakness/Numbness on one side, Difficulty Speaking, Loss of Vision, etc.)		
		SEIZURES (Epilepsy, Convulsions, Blackouts, etc.)		
		NEUROLOGICAL PROBLEMS (Loss of Sensation, Numbness, Tingling, etc.)		ARE YOU RECEIVING TREATMENT FOR GLAUCOMA?
		SEVERE HEADACHES		DO YOU HAVE ANY SPECIAL NEEDS OR CONCERNS? <input type="checkbox"/> Vision _____ <input type="checkbox"/> Hearing _____ <input type="checkbox"/> Speech _____ <input type="checkbox"/> Language _____ <input type="checkbox"/> Translator _____ <input type="checkbox"/> Limitations _____ <input type="checkbox"/> Learning Needs _____
		LUNG PROBLEMS (Asthma, Chronic Cough, Pneumonia, Wheezing, Shortness of Breath, Emphysema, Abnormal Chest X-ray, Oxygen, etc.)		DO YOU HAVE ANY PHYSICAL LIMITATIONS?
		TUBERCULOSIS/TB		DO YOU HAVE ANY ENVIRONMENTAL CONCERNS? (Room Temperature, Lighting, etc.) <input type="checkbox"/> _____
		SLEEP APNEA (Breathing Interruption During Sleep, CPAP, etc.)		DO YOU HAVE ANY SPECIAL REQUESTS?
		LIVER PROBLEMS (Jaundice, Hepatitis, etc.)		DO YOU CURRENTLY NEED ASSISTANCE TO GET AROUND THE HOUSE, DO ERRANDS, AND TAKE CARE OF YOUR PERSONAL NEEDS?
		KIDNEY, BLADDER, OR PROSTATE PROBLEMS (Infections, etc.)		WOULD YOU LIKE TO DISCUSS ANY CONCERNS OR FEARS REGARDING THIS PROCEDURE?
		STOMACH PROBLEMS (Irritable Bowel, Diverticulosis, Nausea/Vomiting, etc.)		WOMEN: IS THERE A POSSIBILITY YOU ARE PREGNANT? LAST MENSTRUAL PERIOD: ARE YOU BREASTFEEDING?
		BOWEL PROBLEMS (Irritable Bowel, Diverticulosis, Diarrhea etc.)		DATE OF LAST IBUPROFEN, ASPIRIN OR BLOOD THINNERS. DATE: _____ LIST: _____
		BACK TROUBLE (Disc Problems, Numbness/Tingling of Hands or Feet, etc.)		PATIENT'S OR SIGNIFICANT OTHERS SIGNATURE RELATIONSHIP DATE
		BROKEN BONES OF HEAD, NECK, OR SPINE OR RESTRICTIONS IN MOVEMENT OR DIFFICULTY OPENING MOUTH (TMJ, etc.)		X
		ARTHRITIS		COMMENTS:
	MUSCLE DISORDERS (MD, Myosthenia Gravis, Myositis, MS, etc.)			
	CANCER			
	MENTAL HEALTH/PHOBIAS (Anxiety, Depression, Psychosis, etc.)			
	MENTAL DISABILITY (Confusion, Memory Loss, Downs Syndrome, etc.)			
	SKIN PROBLEMS (Eczema, Fragile, Rashes, Skin Breakdown, etc.)			
	OTHER MEDICAL PROBLEMS/COMMENTS			
	ANY ILLNESS, COLD, COUGH OR FEVER WITHIN THE LAST WEEK?			
	RECENT EXPOSURE TO ANY COMMUNICABLE DISEASES? (Chicken Pox, Measles, etc.)			
	IF AGE 18 OR OLDER			
	DO YOU HAVE ANY OF THE FOLLOWING? (IF AGE 18 OR OLDER) <input type="checkbox"/> Living Will <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Medical Treatment Plan <input type="checkbox"/> Organ Donor Card		History Completed <input type="checkbox"/> Reviewed by: <input type="checkbox"/> RN _____ <input type="checkbox"/> CRNA _____ <input type="checkbox"/> MD _____	
	Would you like more information <input type="checkbox"/> Yes <input type="checkbox"/> No			