Chart #_________

PATIENT INFORMATION

Patient Name: ____ Date: _____________________
Primary Care Physician: ________________________________ Date of last exam: _________________
DOS/Procedure: ____

List current Medications and Dosages:

____ ____
____ ____
____ ____
____ ____

List all over-the-counter medications (not prescribed by your doctor):

____________________ ____________________ ____________________ _________________

List all Herbal Supplements/remedies:

____________________ ____________________ ____________________ _________________

List all Allergies and Reactions:

____

Medical History: (please check all that apply)

Lung: ___Emphysema ___Asthma ___Shortness of breath ___COPD ___Sleep Apnea: use CPAP? Yes / No
Have you ever had a positive skin test for TB? ____Y ____N if yes, Year: ________ Chest x-rays taken? _______

Cardiovascular: ___High Blood Pressure ___Heart Attack ___Irregular Heartbeat ___Murmur
___Chest Pain ___Stroke/TIA ___Blood Clot ___Valve Problems ___Coronary Artery Disease
___Bruise or Bleed Easily ____Elevated Cholesterol Level ____Blood Disorder

Endocrine: ___Diabetes: Controlled by: ___Oral Medications ___Insulin ___Diet
___Liver Abnormalities ___Thyroid Problem (hypo/hyper)

CNS: ___Epilepsy ___Seizures ___Migraines ___Bell's Palsy ___Nerve damage: Where? _____________________

Psych: ___Anxiety ___Depression ___Bi-Polar ___Schizophrenia ___Other: ___________________

GI: ___Hiatal Hernia ___Acid Reflux ___Ulcers ____IBS ___Diverticulitis ____Crohn's Disease

Urinary: ___Kidney Problems ___Dialysis ___Bladder Problems ___Incontinence

Muscular/Skeletal: ___Osteoarthritis ___Rheumatoid Arthritis ___Fibromyalgia ___Joint Replacement
Can you lay flat? ___Y ___N

Cancer? __Y __N Type: _____________________ Location: ________________________ Date: _________________
Treatment: ___Chemo ___ Radiation ___Surgery Are you in remission? __Y __N

For appropriate anesthesia services to be rendered: Height:______________Weight:_________________lbs_

OTHER: Smoke: ______ pack per day Alcohol: ______drinks per day
Please check all that apply: ___Wear Glasses ___Wear Contacts ___Use Cane ___Use Walker
___Hearing Aid(s) ___Dentures ___Leg/Arm Braces ___ProstheticDevice/Implants
Past Surgeries/Year: ____
____
____
Have you or a blood relative had an unusual reaction to anesthesia? _____You _____Family Member
Reaction: ____
Past Blood Transfusions? ____Yes ____No if yes, Date: __________________ Blood Type: _________________
Have you ever been diagnosed with: _______HIV ______Hepatitis: if yes, what type? _________ Date: _________
Women: Are you pregnant? ____Yes ____No LMP_______________
Hospitalized for reasons other than surgery within the last 5 years? ____
Other diseases, conditions or problems we should know about: ____

Patient Signature: ____ Date: ___________________________