

PRE OPERATIVE PATIENT HEALTH HISTORY

Name _____ Date of Birth _____ Date _____

Describe your present medical symptoms: _____

List any drugs you are allergic to (what was the reaction)? _____

List your current medications (include prescription and non-prescription drugs and birth control pills):

Name	Dosage	Times taken per day

Are you seeing your primary care physician prior to your surgery? Yes No
 If **yes**, when are you seeing your PCP? _____

Have you fasted in preparation for your pre operative tests? Yes No
 When was the last time you ate? _____

For women only – Are you currently menstruating? Yes No

MEDICAL HISTORY

Surgeries:

Type of Surgery	Date	Where treated?

Previous significant medical problems/hospitalizations:

Type of Illness	Date	Where treated?

<p>Do you have any of the following illnesses?</p> <p>Blood Clots <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Give any details of illness:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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SOCIAL HISTORY

Marital Status: _____ Occupation: _____

Current or previous smoker? _____ How much? _____ How many years? _____ Quit date: _____

Do you drink alcohol? _____ Drinks of wine/beer/hard liquor per day/week: _____

Do you use Marijuana? _____ Cocaine? _____ Intravenous Drugs? _____

Do you exercise regularly? _____ Are you opposed to receiving blood products for religious reasons? _____