PATIENT HISTORY

Your Name: ______________________________

Date of Birth: ______________________

Date: ______________

Your Family Doctor ______________________________ **Your Height** ________

Your Pharmacy ______________________________ **Your Weight** ________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (CHECK YES OR NO)

☐YES ☐NO	Diabetes (Insulin, Pills, Diet)	☐YES ☐NO		Sleep apnea
☐YES ☐NO	Heart attack/Surgery ______________	☐YES ☐NO		Emphysema / Asthma / COPD
☐YES ☐NO	High blood pressure ______________	☐YES ☐NO		Stroke ______________________
☐YES ☐NO	Chest pain/Angina ______________	☐YES ☐NO		Bleeding problems
☐YES ☐NO	Arrhythmia	☐YES ☐NO		Hepatitis / AIDS / HIV
☐YES ☐NO	Claustrophobia	☐YES ☐NO		Are you pregnant?
☐YES ☐NO	Kidney Failure/Dialysis	☐YES ☐NO		Heart disease in family ________
☐YES ☐NO	Tuberculosis/night sweats	☐YES ☐NO		Glaucoma in family ________
☐YES ☐NO	Do you need a wheelchair? __________	☐YES ☐NO	☐ QUIT	Do you smoke? ________

Details: ____

List other surgery in past 5 years ____

MEDICATION ALLERGIES: **NO KNOWN ALLERGIES** **LATEX ALLERGY**

DRUG	REACTION	DRUG	REACTION
1.		**4.**	
2.		**5.**	
3.		**6.**	

MEDICATION LIST: LIST ALL CURRENT MEDICATIONS INCLUDING OVER THE COUNTER, HERBAL, AND EYE DROPS

MEDICATION NAME	DOSE (mg, mcg)	ROUTE (orally, IV, nasal)	FREQUENCY (how often)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

DO NOT WRITE BELOW THIS LINE **PRE OPERATIVE ASSESSMENT DONE ON DAY OF SURGERY**

☐ **Anesthesia Provider** __________ ☐ **Pre-Op Nurse** __________ ☐ **OR Nurse** __________ ☐ **PACU Nurse** __________

Medication History provided by:
Patient Family
Physician Office
Pharmacy
Nursing Home
Medication List recorded/
Verification by:

____
Staff Signature
Verified DOS ______________RN

I have reviewed medications, added discharge medications & checked for possible interactions. I have evaluated the patient and the history & physical and do not find any contraindications for Anesthesia/Surgery.

______________________ ____________
Physician Signature Time

TO THE PATIENT: All medications listed above are to be continued as the prescribing doctor instructed. Take this sheet to your next doctor's visit.

______________________________ ____________
Patient Signature Date

(Copy of this sheet given to patient)

UPDATES: DATE______________ NO CHANGES * **SEE CHANGES** MEDS HISTORY BOTH __________