Patient name:

Date of birth:

| **Allergies:** | **Reaction:** |
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**Medication:** Please list all medications taken in the last 30 days; include over the counter, vitamins, herbals, supplements, and medicine taken as needed.

| **Home Medications** | **Dose** | **How often** |
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**Do you have an advance directive or living will?**

**What is the highest level of education you completed?**

**Substance Abuse**

Do you smoke?
How many packs per day?
For how many years?
Any Alcohol use?
If yes, what type?
How often? Daily Weekly Monthly (please circle one)

Any Street drugs?
If yes, what type?

| **Cardiovascular** | **Neurology** | **Skin** | **Reproductive** |
| --- | --- | --- | --- |
| ○ High blood pressure | ○ Migraine | ○ Eczema | ○ Sexually transmitted disease |
| ○ Heart Attack | ○ Stroke (TIA or other) | ○ Psoriasis | ○ Prostate enlargement (BPH) |
| ○ Heart Failure | ○ Head injury | ○ Dermatitis | ○ Breast issues |
| ○ A-Fib (unusual heart beat or rhythm) | ○ Alzheimer’s | ○ Shingles | ○ Fibroids |
| ○ Coronary Artery Disease (blockages in the heart) | ○ Parkinson’s | ○ Rosacea | ○ Endometriosis |
| ○ Peripheral vascular disease (blockages in the head/neck) | ○ Dementia | **Musculoskeletal** | ○ Polycystic ovarian syndrome |
| ○ Blood clots | ○ Seizures | ○ Arthritis | ○ Menstrual disorder |
| **Respiratory** | **Gastrointestinal** | ○ Rheumatoid Arthritis | **Renal/Urinary** |
| ○ Asthma | ○ Acid reflux (GERD) | ○ Osteoarthritis | ○ Kidney stones |
| ○ COPD | ○ Stomach ulcer (peptic ulcer) | ○ Osteopenia | ○ Bladder issues |
| ○ Bronchitis | ○ IBS (irritable bowel) | ○ Osteoporosis | ○ Urinary control issues (incontinence) |
| ○ Sleep apnea | ○ Diverticular disease | ○ Gout | ○ Renal failure (kidney failure) |
| ○ Emphysema | ○ Constipation | ○ Fractures Where? | ○ Urinary tract infections |
| ○ Pneumonia | ○ Hepatitis | ○ Prolapsed disc back/neck | |
| **Ears, Nose, Throat** | ○ Pancreatic issues | ○ Spinal stenosis | |
| ○ Cataracts | ○ Gallbladder issues | ○ Sciatica | |
| ○ Glaucoma | ○ Hernia | **Cancer** | |
| ○ Hearing Loss | **Hematology** | ○ Yes? What KIND? | |
| ○ Sinus issues | ○ Anemia | **Psychological** | |
| ○ Allergic rhinitis | ○ Sickle cell disease | ○ Depression | |
| ○ TMJ | ○ Bleed easily | ○ Anxiety | |
| **Endocrine** | **Immunology** | ○ Bipolar | |
| ○ High cholesterol | ○ HIV | ○ Schizophrenia | |
| ○ Diabetes (type 1 or2) | ○ Lupus | ○ Panic Attacks | |
| ○ Insulin resistance | ○ MRSA/Staph infection | ○ PTSD (post-traumatic stress disorder) | |
| ○ Thyroid problems | | | |

**List Past Surgeries:**

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| Emergency Contact: | Relationship: | Phone Number: |
|---|---|---|
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**Have you had anesthesia before? (Circle one)** YES NO
Any complications with Anesthesia? YES NO
If yes, please explain.

**Have you ever had a blood transfusion? (Circle one)** YES NO
If yes, what year did you receive your blood transfusion?
**Did you have a reaction? (Circle one)** YES NO
If yes, what type of reaction?

**Communication: (circle one)**

| | | |
|---|---|---|
| Hearing problems? | YES | NO |
| Hearing aids? | YES | NO |
| Vision problems? | YES | NO |
| Do you wear glasses or contact lenses? | YES | NO |
| Problems with speech? | YES | NO |
| Difficulty Swallowing? | YES | NO |
| Dentures, partials, caps, crowns, braces, or perm retainer | YES | NO |

Right handed or left handed (please circle one)

**Preferred Language:**

**Tuberculosis Screening:**
Any unexplained weight loss? Fever/Night Sweats?
Persistent cough with blood in it? Recent Exposure to Tuberculosis?

**Functional Mobility Screening**
Are you able to walk without assistance and care for yourself without assistance?
Do you use a cane, crutches, walker, wheelchair, shower chair, oxygen, CPAP, or use any assistive devices?

**Are you or have you participated in a clinical trial or research study in the past year?**

**Do you follow a special diet at home?**

**Diabetes Management**
Do you have diabetes?
Have you been diabetic for less than 6 months?
Do you have an insulin pump?
Is there a time during the day that your sugar drops too low?
Symptoms and what do you do to correct it?

**Is there anyone who would try to get information on you the day of your surgery that you do not want information disclosed to?**

**Who can we release information to?**

**Physician History**
Primary Care Physician:

Other physicians/specialty:

**Elimination**
How often do you have a bowel movement?
Any problems having bowel movements?

Do you have any problems urinating?

**Religion:**
Do you have a religious preference?

**Discharge Planning**
Do you live alone or with family?
Any concerns about home care after procedure?
Do you have a friend or family be here with you during and after surgery?

**Last Menstrual Period?**