



Patient's Name (print)

DOB

Height

Weight

1. Have you ever had any problems with: *(check all that apply)*

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Asthma | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Allergies | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Reaction to anesthetic (<i>General, Local, Sedation</i>) | |

Staff Use Only

Pre-Op Vitals- BP: _____

Pulse: _____ SPO2: _____

Explain any checked boxes: _____

2. Medications routinely used at home: _____

3. What medications, if any, are you allergic to? _____

4. Past surgeries:

Dates	Operation	Type of Anesthesia (<i>General, local, sedation</i>)
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Do you smoke? _____

Packs / Day? _____ Number of years? _____

6. Do you drink alcohol? _____

How often? _____ Drugs? _____

7. Have you ever taken Bisphosphonates (i.e. Boniva, Fosamax)? _____

8. Have you ever had any other health problems we should know about? _____

9. Is there any chance that you may be pregnant? _____

Patient's or Guardian's Signature

Date

Witness Signature

Date

Doctor's Signature

Date