



MEDICAL HISTORY

PREOPERATIVE INFORMATION

TODAY'S DATE _____

NAME _____ HEIGHT _____ WEIGHT _____

ARE YOU PREGNANT? NO _____ YES _____ ARE YOU ALLERGIC TO ANY MEDICATION? NO _____ YES _____

IF YES, WHICH ONE(S)? _____

PLEASE CHECK ALL THAT APPLY TO YOU:

I HAVE HAD OR NOW HAVE:

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bad reaction to a general anesthetic |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Family member with a bad reaction to a general anesthetic |
| <input type="checkbox"/> Respiratory problems (lungs) | <input type="checkbox"/> Required unusually large amounts of local anesthetic for medical or dental procedures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bad reaction to a local anesthetic (novocain etc.) |
| <input type="checkbox"/> Hepatitis or exposure to hepatitis | <input type="checkbox"/> Allergy to adhesive tape |
| <input type="checkbox"/> Jaundice (yellow skin) | <input type="checkbox"/> Scarlet fever or rheumatic fever |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Problem with poor healing |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Large scars or keloids |
| <input type="checkbox"/> AIDS or exposure to AIDS | <input type="checkbox"/> Skin disease, hives, eczema or rash |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent infections or boils |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Serious Illness | <input type="checkbox"/> Significant emotional problems |
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Psychiatric care or advised to see a Psychiatrist |
| <input type="checkbox"/> Bleeding tendencies (yourself or family) | <input type="checkbox"/> Have you ever had polio? |
| <input type="checkbox"/> Other _____ | |
| _____ | |
| _____ | |

MEDICATIONS, DRUGS

What is your approximate DAILY consumption of the following:

Aspirin/Advil/Motrin/Ibuprofen _____ Tobacco _____ Coffee or Tea _____ Alcohol _____

Please list all medications you are now taking including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, blood thinners, aspirin, bufferin, etc.

PREVIOUS SURGERY (please list)

Operation	Year	Hospital	City	Surgeon's Name	Anesthesia (local or general)
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