



Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Sex  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_

**HISTORY**

HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST OR PRESENTLY?

**CARDIAC**

- |                          |                          |                      |
|--------------------------|--------------------------|----------------------|
| Yes                      | No                       |                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease        |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain           |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker            |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heart Beat |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure  |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle Swelling       |

**LUNGS**

- |                          |                          |                |
|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | COPD/Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis     |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma         |
| <input type="checkbox"/> | <input type="checkbox"/> | Use of Oxygen  |

**ENDOCRINE**

- |                          |                          |                   |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes          |
| <input type="checkbox"/> | <input type="checkbox"/> | Insulin Dependant |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid           |

**RENAL**

- |                          |                          |         |
|--------------------------|--------------------------|---------|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidneys |
|--------------------------|--------------------------|---------|

**HEPATIC**

- |                          |                          |                              |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease                |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A B C (circle one) |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                     |

**ANESTHESIA**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Prior anesthesia   |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with Anesthesia   |
| <input type="checkbox"/> | <input type="checkbox"/> | Family Problems w/Anesthesia   |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Cough/Cold  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you aware of the risk of Eating/drinking on the day of anesthesia? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have problems or questions to discuss concerning anesthesia?    |
| <input type="checkbox"/> | <input type="checkbox"/> | Advanced Directive/Living Will   |

**STOMACH**

- |                          |                          |               |
|--------------------------|--------------------------|---------------|
| Yes                      | No                       |               |
| <input type="checkbox"/> | <input type="checkbox"/> | Hiatal Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers        |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn     |

**NEUROLOGICAL**

- |                          |                          |          |
|--------------------------|--------------------------|----------|
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |

**OTHER**

- |                          |                          |                                |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                         |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV / AIDS                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorders                |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnant                       |
|                          |                          | Last Menstrual Cycle Was _____ |

**MUSCULO/SKELETAL**

- |                          |                          |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Back/Neck problems         |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical Restrictions      |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty walking 1 block |

**OTHER**

- |                          |                          |                       |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cortisone/Steroid Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Use           |
| <input type="checkbox"/> | <input type="checkbox"/> | Smoke/Chew            |
|                          |                          | Amount per day        |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin Use Routinely |
| <input type="checkbox"/> | <input type="checkbox"/> | Anticoagulant Use     |

**ALLERGIES**

PLEASE LIST ALL FOOD AND ENVIRONMENTAL ALLERGIES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Latex Allergy Yes  No

**SURGICAL HISTORY**

PRIOR SURGERIES/HOSPITALIZATION

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



PATIENT LABEL

**PATIENTS, PLEASE FILL OUT A COMPLETE LIST OF ALL MEDICATIONS AND DOSAGES  
Include Over The Counter, Vitamins, Herbal**

MEDICATIONS	DOSE	FREQUENCY	PHYSICIAN USE ONLY	
			RESUME	HOLD
1			<input type="checkbox"/>	HOLD UNTIL _____
2			<input type="checkbox"/>	HOLD UNTIL _____
3			<input type="checkbox"/>	HOLD UNTIL _____
4			<input type="checkbox"/>	HOLD UNTIL _____
5			<input type="checkbox"/>	HOLD UNTIL _____
6			<input type="checkbox"/>	HOLD UNTIL _____
7			<input type="checkbox"/>	HOLD UNTIL _____
8			<input type="checkbox"/>	HOLD UNTIL _____
9			<input type="checkbox"/>	HOLD UNTIL _____
10			<input type="checkbox"/>	HOLD UNTIL _____
11			<input type="checkbox"/>	HOLD UNTIL _____
12			<input type="checkbox"/>	HOLD UNTIL _____

FOR PATIENTS TO FILL OUT

<b>New Prescriptions As Of Today</b>
1
2
3

PATIENT: \_\_\_\_\_ PRE-OP NURSE: \_\_\_\_\_

CONTINUE ALL MEDICATIONS AS INDICATED ABOVE

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
*(To be signed upon discharge)*

**I UNDERSTAND AND HAVE RECEIVED A COPY OF THE ABOVE INFORMATION**

PATIENT/RESPONSIBLE ADULT SIGNATURE \_\_\_\_\_ PACU RN SIGNATURE \_\_\_\_\_  
*(To be signed upon discharge)*