

ADMISSION HISTORY

PRIOR TO YOUR SCHEDULED PROCEDURE PLEASE COMPLETE AND FAX, MAIL OR HAVE AVAILABLE WHEN THE NURSES CONTACT YOU FROM THE SURGERY CENTER TO DISCUSS YOUR MEDICAL HISTORY.

DATE OF SERVICE: _____

PATIENT NAME: _____ (M/F) DOB: _____

SURGEON: _____ HEIGHT _____ WEIGHT _____

SCHEDULED PROCEDURE : _____

LIST OF PAST SURGERIES: _____

DRUG ALLERGIES _____

ALCOHOL USE? _____ TOBACCO USE? _____

PLEASE INDICATE MEDICATIONS WITH DOSE & FREQUENCY ON HOME SEPARATE HOME MEDICATION LIST.

IF NO HOME MEDICATIONS, PLEASE CHECK HERE

DO YOU HAVE ANY (circle which applies):

- | | | |
|--|------------------------------|-----------------------------|
| HEART PROBLEMS (High BLOOD PRESSURE, CHOLESTEROL, HEART ATTACK) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| IRREGULAR RHYTHM (A-FIB, PACEMAKER, AICD) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| BREATHING PROBLEMS (SLEEP APNEA, ASTHMA, EMPHYSEMA, COPD, HOME O2) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| DIABETES | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| THYROID DISEASE | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| GLAUCOMA | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HISTORY OF A STROKE OR SEIZURE | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| NEUROGENIC ISSUES (PARKINSONS, ALZHEIMERS) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HISTORY OF CANCER | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| INFECTIOUS DISEASE (HIV, HEPATITIS, SHINGLES, MONO, TB.....) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| KIDNEY OR LIVER ISSUES | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HIGH FEVER AFTER ANESTHESIA/NAUSEA/VOMITING | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ACID REFLUX OR HIATAL HERNIA | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| BLEEDING OR CLOTTING ISSUES | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| PANIC ATTACKS, ANXIETY, OR DEPRESSION | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

OTHER MEDICAL OR SURGICAL HISTORY: