DATE OF SURGERY:	PATIENT'S LAST NAME:	PATIENT'S FIRST NAME:	PATIENT'S DATE OF BIRTH:

PROCEDURE SCHEDULED:	SURGEON'S NAME:		

PEDIATRICS: ☐TAKES BOTTLE ☐USES SIPPY CUP ☐VACCINES CURRENT

ALLERGIES:
☐SEE ATTACHED
☐LATEX
☐NONE
☐MEDICATIONS OR FOODS LISTED BELOW:

NAME	REACTION

CURRENT MEDICATIONS:
☐SEE ATTACHED
☐NONE

NAME & DOSE	FREQUENCY	LAST TAKEN

PROBLEMS WITH ANESTHESIA: ☐NONE
☐UNKNOWN ☐NAUSEA/VOMITING
☐FEVER
☐FAMILY HISTORY

☐OTHER

PREVIOUS SURGERIES/ANESTHESIA: NONE

PATIENT MEDICAL HISTORY (Please circle all that apply):

DIABETES KIDNEY FAILURE ***DIALYSIS*** REFLUX CANCER HEPATITIS LIVER PROBLEMS INTESTINAL PROBLEMS URINARY PROBLEMS THYROID	HIV/AIDS AUTISM MIGRAINES PSYCHIATRIC CONDITION PERIPHERAL NEUROPATHY DEMENTIA ALZHEIMER'S DEVELOPMENTAL DELAY BRAIN INJURY	PANIC ATTACKS ANXIETY SEIZURES *TYPE:*_____ *DATE OF LAST:* _____ MOTION SICKNESS ARTHRITIS FIBROMYALGIA OSTEOPOROSIS HEART MURMUR HIGH BLOOD PRESSURE	BLEEDING DISORDER IRREGULAR HEARTBEAT *TYPE:*_____ HEART ATTACK *DATE/S:*_____ PACEMAKER ***DEFIBRILATING PACEMAKER*** HEART VALVE PROBLEMS CONGESTIVE HEART	CORONARY ARTERY DISEASE ***HEART STENT/S*** *TYPE:*_____ *DATES PLACED:* _____ CHEST PAIN AT REST *HOW OFTEN:* _____ CHEST PAIN WITH ACTIVITY *HOW OFTEN:* _____

PATIENT HEALTH QUESTIONNAIRE

DISORDER	STROKE/TIA	EMBOLISM/DVT	FAILURE	
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) O2 AT HOME: _____*L/hr* TUBERCULOSIS (TB) *DATE OF TREATMENT:* _____	ENVIRONMENTAL ALLERGIES ASTHMA SHORT OF BREATH AT REST SHORT OF BREATH WITH ACTIVITY SLEEP APNEA CPAP BIPAP	DENTURES/PARTIAL DENTAL RETAINER EYE GLASSES CONTACTS HEARING DEVICE/S METAL IMPLANTS *TYPE:*_____ *LOCATION:* _____	***TOBACCO USE:*** CURRENT SMOKER _____PKS/DAY _____YEARS CURRENT CHEW _____YEARS EX-SMOKER/CHEW *DATE QUIT* _____	***DRUG ABUSE:*** TYPE: _____ DATE LAST USED: _____ ALCOHOL DAILY ALCOHOL RARE ALCOHOL OCASSIONALY

Please list below any conditions not listed above along with the date of onset and current status:

_____

_____

_____

_____

Name of responsible driver taking you home on the day of surgery: _____

FOR WOMEN ONLY:

Is there any possibility that you might be pregnant: ☐YES ☐NO

Date of your last menstrual cycle: _____

Have you started menopause? ☐YES Date of onset_____ ☐NO

PATIENT SIGNATURE _____

PATIENT'S REPRESENTATIVE SIGNATURE _____

DATE SIGNED _____

RN SIGNATURE _____

DATE SIGNED _____

CARONDELET Foothills SURGERY CENTER

PATIENT STICKER

PATIENT HEALTH QUESTIONNAIRE