

PLEASE COMPLETE THIS FORM AND BRING WITH YOU AT THE TIME OF YOUR PROCEDURE.

DATE / / PREFERRED NAME:

| | | | | | | |
|--|-------------------------------|--|--|--------------------------------|--|-----|
| PATIENT NAME: | DATE OF BIRTH | GENDER M F | PHONE # | AGE | HT. | WT. |
| PRIMARY SYMPTOM | | PROCEDURE DATE | SURGEON/ DOCTOR | PRIMARY CARE DOCTOR | | |
| ALLERGIES REACTION | <input type="checkbox"/> NONE | <input type="checkbox"/> MEDICATIONS | <input type="checkbox"/> FOODS | <input type="checkbox"/> LATEX | <input type="checkbox"/> OTHERS | |
| | LIST: | | | | | |
| CURRENT AND RECENT MEDICATIONS & HERBAL REMEDIES (INCLUDE PRESCRIPTIONS, EYE DROPS, OVER-THE-COUNTER MEDS / HERBS, ASPIRIN, IBUPROFEN, DIET AIDS & DOSAGE) | | | | | | |
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| HAVE YOU HAD A BAD REACTION TO ANESTHESIA? | | <input type="checkbox"/> YES <input type="checkbox"/> NO | HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA? | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| MEDICAL HISTORY CHECK MAJOR, SIGNIFICANT ILLNESSES WHICH APPLY TO YOU | | | | | | |

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|--|--|--|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> INFLUENZA VACCINE (LAST 12 MO) | GASTROINTESTINAL: |
| <input type="checkbox"/> ANY ILLNESS, COLD, COUGH OR FEVER WITHIN THE LAST WEEK? | <input type="checkbox"/> KIDNEY, BLADDER OR PROSTATE PROBLEMS (INFECTIONS, DISEASE, ETC.) | <input type="checkbox"/> ABDOMINAL PAIN |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> BLACK STOOLS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> BLOATING |
| <input type="checkbox"/> BACK TROUBLE (STRAIN, NUMBNESS / TINGLING OF HANDS OR FEET, ETC.) | <input type="checkbox"/> LUNG PROBLEMS (ASTHMA, CHRONIC COUGH, PNEUMONIA, EMPHYSEMA, ETC.) | <input type="checkbox"/> BLOOD IN STOOL |
| <input type="checkbox"/> BLEEDING / BLOOD DISORDER (BLOOD CLOTS, HEMOPHILIA, ETC.) | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> CHANGE IN BOWEL HABITS |
| <input type="checkbox"/> BOWEL PROBLEMS (IRRITABLE BOWEL, DIVERTICULITIS, ETC.) | <input type="checkbox"/> MENTAL HEALTH / PHOBIAS (ANXIETY, DEPRESSION, PSYCHOSIS, ETC.) | <input type="checkbox"/> CHEST PAIN |
| <input type="checkbox"/> BREAST CANCER | <input type="checkbox"/> MENTAL DISABILITY | <input type="checkbox"/> CONSTIPATION |
| <input type="checkbox"/> BROKEN BONES OF HEAD, NECK OR SPINE, OR RESTRICTIONS IN MOVEMENT | <input type="checkbox"/> MUSCLE DISORDERS (MD, MYASTHENIA GRAVIS, ETC.) | <input type="checkbox"/> COUGH, SHORTNESS OF BREATH |
| <input type="checkbox"/> CANCER (LIST) | <input type="checkbox"/> NEUROLOGICAL PROBLEMS - NUMBNESS, TINGLING | <input type="checkbox"/> DIARRHEA |
| <input type="checkbox"/> CATARACTS | <input type="checkbox"/> PNEUMOVAX VACCINE | <input type="checkbox"/> FATIGUE |
| <input type="checkbox"/> COLITIS | <input type="checkbox"/> RECENT EXPOSURE TO ANY COMMUNICABLE DISEASES? | <input type="checkbox"/> GAS |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HISTORY OF POLYPS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> SEVERE HEADACHES | <input type="checkbox"/> NAUSEA/VOMITING |
| <input type="checkbox"/> DIFFICULTY OPENING MOUTH (TMJ, ETC.) | <input type="checkbox"/> SKIN PROBLEMS (ECZEMA, FRAGILE, ETC.) | <input type="checkbox"/> RECTAL BLEEDING |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> SLEEP APNEA | <input type="checkbox"/> RECTAL PAIN |
| <input type="checkbox"/> EPILEPSY / SEIZURES | <input type="checkbox"/> STROKE | <input type="checkbox"/> SWALLOWING DIFFICULTIES |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> STOMACH PROBLEMS (ULCER, HIATAL HERNIA, REFLUX, HEARTBURN, COUGH, ETC.) | <input type="checkbox"/> VOMITING BLOOD |
| <input type="checkbox"/> HAY FEVER | <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> WEIGHT LOSS - AMOUNT _____ TIME _____ |
| <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> TUBERCULOSIS / TB | CARDIOVASCULAR: |
| <input type="checkbox"/> HEPATITIS / JAUNDICE | <input type="checkbox"/> ULCERS | <input type="checkbox"/> ABNORMAL HEART BEAT |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> OTHERS NOT LISTED: _____ | <input type="checkbox"/> USE OF BLOOD THINNER |
| <input type="checkbox"/> HIV / AIDS | _____ | |
| <input type="checkbox"/> HYPOGLYCEMIA (LOW BLOOD SUGAR) | _____ | |

| PATIENT HISTORY | | | | | |
|-----------------|----|--|-----|----|--|
| YES | NO | DO YOU HAVE ANY OF THE FOLLOWING: <input type="checkbox"/> FALSE TEETH <input type="checkbox"/> CHIPPED TEETH <input type="checkbox"/> BRACES <input type="checkbox"/> BRIDGES <input type="checkbox"/> LOOSE TEETH <input type="checkbox"/> CAPS / CROWNS <input type="checkbox"/> RETAINERS <input type="checkbox"/> BODY PIERCING | YES | NO | DO YOU HAVE SPECIAL COMMUNICATION NEEDS? <input type="checkbox"/> VISION <input type="checkbox"/> HEARING <input type="checkbox"/> LANGUAGE <input type="checkbox"/> SPEECH |
| | | | | | |
| YES | NO | DO YOU WEAR CONTACT LENSES? | YES | NO | ARE YOU RECEIVING TREATMENT FOR GLAUCOMA? |
| | | | | | |
| YES | NO | DO YOU HAVE PHYSICAL LIMITATIONS? | YES | NO | DO YOU HAVE ANY ENVIRONMENTAL CONCERNS? (ROOM TEMPERATURE, LIGHTING, ETC.) |
| | | | | | |

THIS FACILITY WILL NOT BE RESPONSIBLE FOR PERSONAL BELONGINGS AND VALUABLES. AS MANY BELONGINGS AND VALUABLES AS POSSIBLE SHOULD BE TAKEN HOME BY FAMILY MEMBERS.

X _____ DATE _____ RELATIONSHIP _____
PATIENTS OR RESPONSIBLE PARTY'S SIGNATURE

For facility use only

Reviewed by: _____
Staff Signature

Date _____

(CONTINUED ON BACK)

**SURGICAL / HOSPITAL
LIST THE YEAR OF ANY OPERATIONS / PROCEDURES YOU HAVE HAD**

| | | | | | |
|--------------------------|------------------------------------|--------------------------|--|--------------------------|------------------------------|
| YR: <input type="text"/> | APPENDIX SURGERY | YR: <input type="text"/> | GASTROSCOPY / EGD (LOOKING INTO STOMACH) | YR: <input type="text"/> | PLASTIC SURGERY |
| YR: <input type="text"/> | BREAST GROWTH REMOVAL | YR: <input type="text"/> | GASTRIC SURGERY | YR: <input type="text"/> | POLYP REMOVED FROM INTESTINE |
| YR: <input type="text"/> | CARPAL TUNNEL | YR: <input type="text"/> | HEART CATHETERIZATION / SURGERY | YR: <input type="text"/> | PROSTATE SURGERY |
| YR: <input type="text"/> | CATARACT SURGERY | YR: <input type="text"/> | HEART SURGERY | YR: <input type="text"/> | THYROID SURGERY |
| YR: <input type="text"/> | CESAREAN SECTION DELIVERY | YR: <input type="text"/> | HERNIA | YR: <input type="text"/> | TONSILS / ADENOIDS REMOVED |
| YR: <input type="text"/> | COLONOSCOPY (LOOKING INTO BOWEL) | YR: <input type="text"/> | HIP SURGERY | YR: <input type="text"/> | TUBAL LIGATION |
| YR: <input type="text"/> | COLON SURGERY | YR: <input type="text"/> | HYSTERECTOMY | YR: <input type="text"/> | VASECTOMY |
| YR: <input type="text"/> | D&C | YR: <input type="text"/> | NASAL / SINUS SURGERY | YR: <input type="text"/> | OTHER: _____ |
| YR: <input type="text"/> | GALL BLADDER SURGERY / LAPAROSCOPY | YR: <input type="text"/> | KNEE SURGERY | _____ | |

| | |
|---|------|
| LIST ANY TRAUMA / BROKEN BONES / SERIOUS ACCIDENTS: | YEAR |
|---|------|

LIST OTHER DOCTORS YOU HAVE SEEN? _____

FAMILY HISTORY

| | |
|---|--|
| ARE YOU ADOPTED? <input type="checkbox"/> YES <input type="checkbox"/> NO | LIST THE CAUSE OF DEATH FOR THOSE WHO HAVE DIED PRIOR TO AGE 50 (DO NOT INCLUDE ACCIDENTAL DEATHS) |
| | FATHER _____ MOTHER'S FATHER _____ FATHER'S FATHER _____ |
| | MOTHER _____ MOTHER'S MOTHER _____ FATHER'S MOTHER _____ |

CHECK ANY ILLNESSES WHICH HAVE OCCURRED IN A BLOOD RELATED BROTHER (B), SISTER (S), MOTHER (M), FATHER (F) OR GRANDPARENT (G) WHO

| | |
|---|---|
| <input type="checkbox"/> ALCOHOLISM / SUBSTANCE ABUSE _____ | <input type="checkbox"/> EMOTIONAL / MENTAL ILLNESS / SUICIDE _____ |
| <input type="checkbox"/> ALZHEIMER'S / DEMENTIA _____ | <input type="checkbox"/> HIGH BLOOD PRESSURE _____ |
| <input type="checkbox"/> CANCER (BREAST) _____ | <input type="checkbox"/> HEART ATTACK PRIOR TO AGE 55 _____ |
| <input type="checkbox"/> CANCER (COLON) _____ | <input type="checkbox"/> OSTEOPOROSIS _____ |
| <input type="checkbox"/> CANCER (PROSTATE) _____ | <input type="checkbox"/> POLYPS _____ |
| <input type="checkbox"/> CANCER (OTHER) _____ | <input type="checkbox"/> STROKE _____ |
| <input type="checkbox"/> COLITIS _____ | <input type="checkbox"/> TUBERCULOSIS _____ |
| <input type="checkbox"/> CROHN'S _____ | <input type="checkbox"/> UTERINE / OVARIAN CANCER _____ |
| <input type="checkbox"/> DIABETES _____ | |

SOCIAL HISTORY

| | | | |
|--------|--|-------------|---|
| YES NO | HAVE YOU TRAVELED OUTSIDE THE US (OTHER THAN MILITARY)? | NON DRINKER | ON AVERAGE HOW MANY ALCOHOLIC DRINKS (1 DRINK = 12 OZ. BEER, 10 OZ. WINE COOLER, 5 OZ. WINE, 1.5 OZ. LIQUOR) DO YOU CONSUME DURING ONE DAY? <input type="checkbox"/> ONE <input type="checkbox"/> TWO <input type="checkbox"/> THREE <input type="checkbox"/> FOUR HOW MANY DO YOU CONSUME AT ANY ONE TIME? _____ HAVE YOU EVER THOUGHT YOU HAD A PROBLEM WITH DRINKING? _____ |
| YES NO | DO YOU NEED HELP FROM YOUR DOCTOR FOR AN ISSUE RELATED TO DRUGS? | NEVER | |
| YES NO | DO YOU NEED HELP FROM YOUR DOCTOR FOR A PROBLEM RELATED TO PHYSICAL, VERBAL, OR MENTAL ABUSE? | | |
| YES NO | ARE YOU AT RISK FOR AIDS / (HIV) / (HOMOSEXUAL, BISEXUAL, MULTIPLE SEX PARTNERS, NEEDLE DRUG USE OTHER THAN INSULIN) | | |
| | | | WHAT IS YOUR SMOKING STATUS? <input type="checkbox"/> SMOKELESS <input type="checkbox"/> CIGAR <input type="checkbox"/> PIPE <input type="checkbox"/> CIGARETTE AVERAGE NUMBER OF PACKS A DAY? _____ YEAR QUIT _____ NUMBER OF YEARS SMOKED _____ WOULD YOU LIKE HELP TO QUIT? _____ |

The conscious sedation medications we use have not been proven to be safe in pregnancy. If you are pregnant or think you might be pregnant, please notify us.

PATIENT NAME: _____ DATE OF BIRTH: _____

Do you have a living will? Yes No
 Do you have a durable/special power of attorney? Yes No
 Do you have a medical treatment plan? Yes No
 Would you like more information? Yes No
 Do you have a Physician Order for life Sustaining Treatment (POLST)? Yes No