

Patient name _____ Today's date _____

Please list your prescription medications, vitamins and over-the-counter medications

Medication name	Dosage	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications? If so, please list.

Medication name	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What operations have you had?

Operation	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(over)

Patient name _____ Today's date _____

	Yes	No
ARE YOU ALLERGIC TO LATEX?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>

Do you have a history of

	Yes	No
cancer?	<input type="checkbox"/>	<input type="checkbox"/>
diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
coronary artery disease?	<input type="checkbox"/>	<input type="checkbox"/>
liver problems?	<input type="checkbox"/>	<input type="checkbox"/>
asthma?	<input type="checkbox"/>	<input type="checkbox"/>
blood clots/thrombophlebitis?	<input type="checkbox"/>	<input type="checkbox"/>
bleeding problems?	<input type="checkbox"/>	<input type="checkbox"/>
family member with bleeding problems?	<input type="checkbox"/>	<input type="checkbox"/>
stomach ulcers?	<input type="checkbox"/>	<input type="checkbox"/>
urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>

Are there any other medical diagnoses you carry?

Are <u>you</u> color blind	<input type="checkbox"/>	<input type="checkbox"/>
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Have you or an immediate family member ever had a problem with anesthesia (other than nausea)?

	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

(over)