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?	□	□

	Yes	No
Do you smoke?	□	□
Do you drink alcohol?	□	□

Do you have a history of

	Yes	No
cancer?	□	□
diabetes?	□	□
high blood pressure?	□	□
heart attack?	□	□
coronary artery disease?	□	□
liver problems?	□	□
asthma?	□	□
blood clots/thrombophlebitis?	□	□
bleeding problems?	□	□
family member with bleeding problems?	□	□
stomach ulcers?	□	□
urinary tract infections	□	□

Are there any other medical diagnoses you carry?

_____

_____

_____

_____

Are you color blind	□	□

Have you or an immediate family member ever had a problem with anesthesia (other than nausea)?

Yes	No
□	□

(over)