ADMISSION HISTORY

PRIOR TO YOUR SCHEDULED PROCEDURE PLEASE COMPLETE FULLY AND FAX, MAIL, OR DROP OFF AT OUR FRONT DESK.

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 one applies, then circle Yes or No):

HEART PROBLEMS (HIGH BLOOD PRESSURE, CHOLESTEROL, HEART ATTACK, CARDIAC STENT IN LAST 90 DAYS)	0 YES	0 NO
IRREGULAR RHYTHM (A-FIB, PACEMAKER, AICD)	0 YES	0 NO
BREATHING PROBLEMS (SLEEP APNEA, ASTHMA, EMPHYSEMA, COPD, HOME OXYGEN)	0 YES	0 NO
DIABETES	0 YES	0 NO
THYROID DISEASE	0 YES	0 NO
GLAUCOMA	0 YES	0 NO
HAVE YOU EVER HAD A STROKE OR SEIZURE	0 YES	0 NO
NEUROGENIC ISSUES(PARKINSONS, ALZHEIMERS, DEMENTIA)	0 YES	0 NO
HAVE YOU EVER BEEN DIAGNOSED WITH CANCER	0 YES	0 NO
INFECTIONS DISEASE (HIV, HEPATITIS, SHINGLES, MONO, TB)	0 YES	0 NO
KIDNEY OR LIVER ISSUES (DIALYSIS)	0 YES	0 NO
HAVE YOU OR ANYONE THAT YOU ARE DIRECTLY RELATED TO EVER HAD A HIGH FEVER AFTER ANESTHESIA	0 YES	0 NO
ACID REFLUX OR HIATAL HERNIA	0 YES	0 NO
BLEEDING OR CLOTTING ISSUES	0 YES	0 NO
PANIC ATTACKS, ANXIETY, OR DEPRESSION	0 YES	0 NO
HAVE YOU BEEN OUT OF THE COUNTRY IN THE LAST 90 DAYS	0 YES	0 NO
DO YOU NEED ASSISTANCE WITH WALKING (CANE, WHEELCHAIR, WALKER)	0 YES	0 NO

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