

PRECISION SURGICENTER

39180 Farwell Drive, Suite 100
Fremont, CA 94538

Date : _____ Age: _____ Height: _____ Weight: _____ Sex: _____

Name _____

Previous Operations	When and Where	General	Nerve Block	Spinal/Epidural	Complications?

FAMILY HISTORY OF ANESTHETIC COMPLICATIONS? NO YES _____

DRUG ALLERGIES NO YES _____

MEDICINES CURRENTLY TAKEN: NONE
(includes Vitamins/Herbs/Supplementals)

Medication	Dose	Times Per Day

Check below if you have or ever have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease/ESRD/Dialysis |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Ulcers/Hiatal Hernia/Reflux |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> COPD | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Angina / Chest Pain | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Abnormal ECG | <input type="checkbox"/> Abnormal Chest X-ray | <input type="checkbox"/> Steroid/Cortisone |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Heavy Snoring | <input type="checkbox"/> Dentures / Partial Plates |
| <input type="checkbox"/> Murmur / Valve Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Capped Teeth |
| <input type="checkbox"/> Exercise Limitation | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Chipped/Loose Teeth |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Gum Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Transient/Ischemic Attack | <input type="checkbox"/> Hypo / Hyperthyroid | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Numbness / Weakness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Drug / Substance Abuse |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Aids / HIV | Are you pregnant? Y / N |
| <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Recent Infectious Exposure | Might you be pregnant? Y / N |
| <input type="checkbox"/> Motion Sickness / Fainting | <input type="checkbox"/> Diabetes | |

Other Medical Problems: _____

Smoker Nonsmoker

How many packs do you smoke per day? _____ How many Years? _____ Quit Date _____

Do you drink alcohol? None Occasionally Daily

Patient Signature:

Date

