Sarah Sandell, M.D. F.A.C.P.
Susan Sleep, M.D.

3742 Katella Ave., Suite 302
Los Alamitos, CA 90720
Phone: (562) 936-0292 Fax: (562) 936-1943

PREOPERATIVE HISTORY FORM

NAME ____ D.O.B. _____/______/_____ Todays Date _____/_____/______

Type of surgery ____

Date and Location Surgery where will be performed ____

Previous surgeries (include date if known)

____

____

____

Have you or a family member had complications after surgery of anesthesia (and if so please provide details):

____

____

List **ALL current medicines AND supplements** you are taking and include dose (mg):

____

____

____

____

____

Do you use tobacco products? ___________ Do you use any recreational drugs including marijuana? ________

Do you drink alcohol and if so how much and how often? ____

Do you have any concerns regarding the surgery?

____

____

PATIENT INFORMATION PAGE 2 FOR NAME: ______________________________ D.O.B. _________

Please check if you are having a problem with any of the following now:
Fever _____ Chills _____ Fatigue _____ Night sweats _____ Hot flush _____ Weight loss _____ Weight gain _____
Changes in hair _____ Weakness _____ Rash _____ Dry skin _____
Changes in nails _____ Itching _____ New skin growths or changes of concern ____________________________

Visual disturbance _____ Double vision _____ Glaucoma _____ Cataracts _____ Eye pain _____ Hearing loss _____
Ringing in your ears _____ Ear pain _____ Nasal congestion _____ Nose bleeds _____ Sinus problems _____
Problems with your teeth/gums _____ Hoarseness _____ Sore throat _____ Snoring _____
Neck pain _____ Swollen "glands" _____ Difficulty swallowing _____ Thyroid problems _____
Other problems with your eyes, ears, nose, throat, neck ____

Breast pain _____ Breast lumps _____ Nipple discharge _____ Other breast problems __________

Cough _____ Excessive or bloody sputum _____ Wheezing _____ Asthma _____ Bronchitis _____ Pneumonia _____
Other problems with your lungs/breathing ____

Palpitation _____ Arrhythmia _____ Edema _____ Shortness of breath (at rest or with exertion) _____
Valvular heart disease _____ Other heart problems _____

Leg pain/cramps _____ Phlebitis _____ Back pain _____ Neck pain _____ Hip pain _____ Groin pain _____
Knee pain _____ Arm or shoulder pain _____ Arthritis _____ Gout _____ Other musculoskeletal problems _____

Heartburn/indigestion _____ Change in appetite _____ Nausea or vomiting _____ Change in bowel habits _____
Constipation _____ Diarrhea _____ Blood in your stool _____ Black stools _____ Hepatits _____
Irritable bowel _____ Colitis _____ Gallstones _____ Liver disease _____ Hemorrhoids _____ Abdominal pain _____
Food intolerance _____ Histoy of Ulcer disease _____ Other intestinal problems ____________________________

Anemia _____ Excessive bleeding/bruising _____ History of blood clots _____ Other blood disorder _______
History of blood product transfusion (if so what/when/how much) __________________________

History of diabetes _____ Excessive thirst or urination _____ Intolerance to heat or cold _____
Anxiety _____ Depression _____ Difficulty sleeping _____ Other mood disturbance __________________________
Fainting _____ Dizziness _____ Seizure _____ Stroke _____ Tremors _____ Localized weakness or numbness _____
Problems with memory _____ Headache _____ Other neurological problems ____________________

Urinary frequency/urgency _____ Incontinence _____ Urinary tract infection _____ Blood in urine _____
Kidney stones _____ Other problems urintating or change in urination ______________________
History of a sexual transmitted diease. If so, describe ______________________________
Problems with sexual desire or function ________________
Number of sexual partners in the past few years _____ Men _____ Women _____ Both _____
Females: Vaginal discharge _____ Pain with intercourse _____ Other problems _______
If still menstruating: My period occurs every _____ days and lasts for _____ days. Are your periods regular?
Yes/No _____ Heavy Yes/No _____ Bleed in between actual period Yes/No _____ Severe cramps Yes/No _____
Check if no longer having menstrual periods _____ # of previous pregnancies _____ Miscarriage/Abortion _____
Males: Pain in testicles/penis _____ Penile discharge _____ Prostate problems _____ Other problems _________

Other problems not listed above: ____ ______________________________ ____________________________

NAME ____ DATE ______/______/______

NAME OF MEDICATION/ VITAMINS/SUPPLIMENTS	DOSE (mg)	TIME taken	REASON TAKING	DR (who prescribed it)