Preoperative History Form

Name *Date of Birth* *Today's Date*

Type of surgery _____

Date and Location where Surgery 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):

Current Medications PLEASE FILL OUT A SEPARATE FORM IN DETAIL LISTING PRESCRIPTION MEDICATION AND SUPPLEMENTS. It is important to fill this out with ALL the information.

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?

Any additional information:

Patient Information Page Two 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 ☐ Hepatitis ☐ Irritable bowel ☐ Colitis ☐ Gallstones ☐ Liver disease ☐ Hemorrhoids
☐ Abdominal pain ☐ Food intolerance ☐ History 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 urinating or change in urination ☐ History of a sexual transmitted disease 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 ☐ No # of previous pregnancies _____ Miscarriage/Abortion _____

Males: ☐ Pain in testicles/penis ☐ Penile discharge ☐ Prostate problems Other problems: _____
Other problems not listed above _____

NAME _____ DATE ____/____/____

Name _____ Date ____/____/____

Medication/ Vitamins/Supplements	DOSE (mg)	TIME taken	REASON TAKING	Dr (who prescribed it)