

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 ____/____/____

