

Seven Hills Surgery Center Surgical and Medical History

PLEASE FILL OUT FRONT AND BACK AND BRING WITH YOU TO SURGERY CENTER ON SURGERY DAY!

Patient's Name: _____ **Date of Surgery:** _____

Information on this form filled out by: **Patient** _____ **Parent** _____ **Legal Guardian** _____

- **If Legal Guardian:** Written legal proof of Guardianship must be available

Allergies (include Latex, food and adhesives)

Past Medical History: Have you ever had any of the following conditions? Please check all that apply

<input type="checkbox"/> Stroke <input type="checkbox"/> Seizure/Epilepsy/Fainting <input type="checkbox"/> Meningitis <input type="checkbox"/> Polio <input type="checkbox"/> Paralysis Heart Disease: <input type="checkbox"/> Chest Pain (Angina) <input type="checkbox"/> Heart Attack <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Bypass <input type="checkbox"/> Pacemaker <input type="checkbox"/> Gallbladder Trouble <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Back Pain Other: _____	<input type="checkbox"/> Emphysema <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Hypo/Hyper Thyroid <input type="checkbox"/> Peptic Ulcer <input type="checkbox"/> Liver Trouble <input type="checkbox"/> High Fevers <input type="checkbox"/> Asthma <input type="checkbox"/> Night Sweats <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> HIV Positive/AIDS	<input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney Trouble <input type="checkbox"/> Dialysis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sickle Cell Trait <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> CPAP or BiPap <input type="checkbox"/> Esophageal Reflux (Heartburn) <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Cancer – Type: _____ <input type="checkbox"/> Difficulty opening mouth/jaw
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If none of the above conditions apply, please check here _____

- Name of Primary Care Physician and all other physicians currently seeing you:
- _____
- _____

- Have you ever **smoked**? YES NO If yes, how long? _____
- Do you currently **smoke**? YES NO
- Do you **drink alcoholic beverages**? YES NO If yes, how long? _____
- Do you use any **recreational drugs**? YES NO If yes, type and amount: _____
- Are you **currently pregnant**? YES NO Last menstrual cycle: _____
- Any serious illness during pregnancy? YES NO If yes, what type? _____

Do you have any of the following? (Please circle all that apply):

Dentures _____ Loose Teeth _____ Body Piercing _____ Prosthesis (type) _____

Surgical Procedures: (This includes any procedure performed in a hospital or outpatient setting in which anesthesia has been used.)

• **PLEASE START WITH THE MOST RECENT SURGERY**

1. Name and Date of Surgery _____
2. Name and Date of Surgery _____
3. Name and Date of Surgery _____
4. Name and Date of Surgery _____
5. Name and Date of Surgery _____

• **ANY COMPLICATIONS WITH SURGERY?** (i.e. excessive bleeding) YES / NO
If yes, please explain: _____

• **HAVE YOU OR YOUR FAMILY MEMBERS EVER HAD ANY COMPLICATIONS WITH ANESTHESIA?** (i.e. difficulty breathing, difficulty awaking from surgery, heart problems, malignant hyperthermia, nausea or vomiting) YES / NO
If yes, please explain: _____

• Have you EVER taken a medication to help you urinate such as Flomax ? YES / NO

Medications: (Prescription OR over-the-counter)

Name	Dose	Frequency/Reason for taking
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

DO NOT WRITE IN THE SPACE BELOW

- Allergies: _____ Gauge _____
- Vital Signs: B/P _____ HR _____ RR _____ O2 SAT _____ WT _____
- ANESTHESIOLOGY PRE-OP: Appearance: _____ ASA Class: _____ Plan: _____
Airway/Dental: _____ Heart: _____ Lungs: _____ Lab/Diag Studies: _____ Resp: _____
- Consent signed YES / NO MH: _____ FBS: _____
- Possible Risk/Complications and Alternatives explained YES / NO
- Comments: _____

Physician's Signature _____