



### PATIENT MEDICAL HISTORY FORM

Please complete this form and bring it with you to the Surgery Center. Use a second sheet of paper if necessary. Please feel free to call us for any questions.

NAME \_\_\_\_\_ SURGERY DATE \_\_\_\_\_

Please list any medications you are allergic to and the reaction you have.

ALLERGIES	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

Please call us if you are allergic to LATEX. Are you allergic to SOY or EGG PRODUCTS?  NO  YES

Please list prescription medications you are taking.	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list over-the-counter and herbal medications you are taking.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous Surgeries	Date	Hospital/Surgery Center
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any previous problems with anesthesia?  NO  YES (Please explain)

\_\_\_\_\_

\_\_\_\_\_

Do you have a family history of problems with anesthesia?  NO  YES (Please explain)

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Please list your medical problems. (Examples: heart disease, high blood pressure, hepatitis)

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Do you have any implantable medical devices such as a pacemaker?  NO  YES

If so please list the device and the manufacturer and model number if known. If you have a device information card please bring it with you the day of your procedure. \_\_\_\_\_

Do you sign your own legal documents?  NO  YES

If you answered NO, please bring the person who signs for you and the legal documentation with you to the Surgery Center the day of your procedure.

If you are completing this form for a minor child, are you the child's parent?

YES Name \_\_\_\_\_

NO Name and relationship to the child \_\_\_\_\_

If you answered NO, please bring your legal papers establishing guardianship with you to the Surgery Center.

Do you have any questions or concerns you would like to discuss or bring to our attention?

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SIGNATURE \_\_\_\_\_