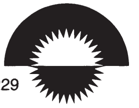
GREATER SACRAMENTO SURGERY CENTER
2288 AUBURN BLVD., SUITE 201 • SACRAMENTO, CA 95821 • (916) 929-7229



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)

____

____

(over)

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

____

____

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

____

____

____

Do you have any implantable medical devices such as a defibrillator? ☐ NO ☐ YES If yes, call Surgery Center.
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.
Do you have an advance directive? ☐ NO ☐ YES If yes, please bring a copy.

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?

____

____

____

SIGNATURE ______________________________________