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

_____Stroke
_____Seizure/Epilepsy/Fainting
_____Meningitis
_____Polio
_____Paralysis
Heart Disease:
_____Chest Pain (Angina)
_____Heart Attack
_____Congestive Heart Failure
_____Irregular Heartbeat
_____Mitral Valve Prolapse
_____Heart Murmur
_____Heart Bypass
_____Pacemaker
_____Gallbladder Trouble
_____High Blood Pressure
_____Back Pain
Other: _____

_____Emphysema
_____Bronchitis
_____Pneumonia
_____Tuberculosis
_____Sinusitis
_____Chronic Cough
_____Mononucleosis

_____Hypo/Hyper Thyroid
_____Peptic Ulcer
_____Liver Trouble
_____High Fevers
_____Asthma
_____Night Sweats
_____Dementia
_____Alzheimer's disease
_____HIV Positive/AIDS

_____Diabetes
_____Kidney Trouble
_____Dialysis
_____Rheumatic Fever
_____Sickle Cell Disease
_____Sickle Cell Trait
_____Sleep Apnea
_____CPAP or BiPap
_____Esophageal Reflux (Heartburn)
_____Hiatal Hernia
_____Cancer – Type:
_____

_____Difficulty opening mouth/jaw

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_____ 02 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 _____