



Patient Name: _____ Date Scheduled for Surgery: _____

Surgeon: _____ Procedure: _____

Date of Birth: _____ Sex: _____

Patient History

Psychological: (Circle your answer)

Depression/Anxiety/Alzheimer/Bipolar/Claustrophobic Y N

Metabolic:

Diabetic: I II High Blood Sugar Y N

Hyper / Hypo Thyroid Y N

Neuro:

CVA/Seizure Disorder/Transient Ischemia Y N

Chronic Migraines/HA Y N

Muscular Weakness: Y N

Upper Extremities: Side Right Left

Lower Extremities: Side Right Left

BackPain/NeckPain/Arthritis Y N

Pulmonary:

Asthma/COPD/Emphysema Y N

Cough/Dry/Productive Y N

Sleep Apnea / CPAP Y N

Cardiac:

Coronary Artery Disease/Heart Attack/High Blood Pressure/Congestive Heart Failure/
Mitral Valve Prolapse Y N

High Cholesterol Y N

Pacemaker/ICD/Valve Implant Y N

GI:

Hiatal Hernia/Gastroesophageal Reflux Disease/Peptic Ulcer Y N

Appetite: Excellent Good Fair Poor

GU:

Renal Failure/Dialysis/Chronic Urinary Tract Infection Y N

Infectious Diagnosis /MRSA/TB/Hepatitis Type: _____ Y N

Recent Cold/Flu/Upper Respiratory Infection Y N

Blood thinners/Bleeding disorders Y N

Blood Transfusion/Reaction Date _____ Y N

Cancer Type: _____ Y N

Menopause/Hysterectomy/L.M.C. Date _____ Y N