Please fill out form carefully and completely.

Pre-Op History & Physical

Name: ______________________________ Chart #: ______________

Cardiologist: ____________________ Height: ________ Weight: ________

Family physician: ________________ Date of last visit: ________ BMI: ________

Medical Power of Attorney/Health Surrogate? ❑ Yes ❑ No (If, yes: Name: ______________________)

Are you allergic to **LATEX**? ❑ Yes ❑ No

List other allergies and sensitivities including reaction:

____

____

List ALL previous surgeries:

____

____

Check **YES NO** for **Each Disease or Item**

Have you had LASIK or RK eye surgery? ❑Yes ❑No

Yes No Cardiovascular Disease

- ❑ ❑ **Heart Attack Date: ________**
- ❑ ❑ **Heart Bypass surgery/stenting Bypass/Stent Date: ________**
- ❑ ❑ High Blood Pressure
- ❑ ❑ Low Blood Pressure
- ❑ ❑ **Chest Pain**
- ❑ ❑ **Arrhythmias/Atrial fibrillation**
- ❑ ❑ **Heart Failure**
- ❑ ❑ **Valve Disease/Heart Murmur**
- ❑ ❑ **Pacemaker/Defibrillator**
- ❑ ❑ Shortness of Breath when climbing stairs

Yes No Kidney/Urinary Disease

- ❑ ❑ **Chronic Kidney Disease Stage: ________**

Yes No Endocrine Disease

- ❑ ❑ Diabetes

Yes No Pulmonary Disease

- ❑ ❑ Asthma
- ❑ ❑ **Emphysema/COPD**
- ❑ ❑ Bronchitis/Chronic Cough
- ❑ ❑ **Recent Respiratory Infection Date: ______**

Yes No Infectious Diseases

- ❑ ❑ MRSA/VRE
- ❑ ❑ HIV
- ❑ ❑ Hepatitis A B C /Jaundice

Yes No GI Disease

- ❑ ❑ Acid Reflux/GERD

Yes No Neurological Disease

- ❑ ❑ **Seizures/Epilepsy Date: ________**
- ❑ ❑ **Dementia/Alzheimer's**
- ❑ ❑ **Mini-Stroke/TIA Date: ________**
- ❑ ❑ **Stroke Date: ________**

Yes No Substance Use

- ❑ ❑ Recreational drug use
- ❑ ❑ Drink Alcohol: Last use ________
- ❑ ❑ Smoking Packs/day ____for ____yrs

Yes No Other

- ❑ ❑ **Active Cancer Type: ____________**
- ❑ ❑ **Chemo/Radiation within last 3 months**
- ❑ ❑ **Clotting/Bleeding Problems**
- ❑ ❑ Claustrophobia
- ❑ ❑ Difficulty Lying Flat
- ❑ ❑ Restless Leg Syndrome

Yes No Anesthesia

- ❑ ❑ Personal History of Anesthesia problems
- ❑ ❑ Family History of Anesthesia problems
- ❑ ❑ Difficulty with Jaw Opening
- ❑ ❑ Difficult Intubation
- ❑ ❑ Missing/Loose/Chipped Teeth
- ❑ ❑ Dentures/Fixed Bridge

Other History: ______________________________

List Below ALL of your medications including over-the-counter, vitamins, and herbal supplements

Medication	Dose	How often?

Do you take any blood thinners?
❑**Yes** ❑**No**

Do you take any aspirin products?
❑**Yes** ❑**No**

Do you have a history of taking IFIS drugs?
❑**Yes** ❑**No**

Reviewed by:

____

____

The above information is true and correct to the best of my knowledge.

Patient Signature ______________________________ Date: ________