CENTER FOR OUTPATIENT SURGERY

TO BE COMPLETED BY PATIENT (OR PARENT / LEGAL GUARDIAN)

PRE-ANESTHESIA INFORMATION

YOUR NAME _____ HEIGHT _____ WEIGHT _____ AGE _____

ALLERGIES
Yes ☐ No ☐ If yes, please list _____

MEDICATIONS
Do you take any medication on a regular basis?
Yes ☐ No ☐ If yes, please list _____

OPERATIONS
What operations have you had in the past? Any complications?
Please list: _____

ANESTHESIA COMPLICATIONS
Have you or any family member had any problems in connection with anesthesia?
Yes ☐ No ☐ If yes, please explain _____

MEDICAL HISTORY
Have you had or do you presently have any of the following conditions?

☐ Arthritis	☐ Diabetes	☐ Lung Trouble
☐ Asthma	☐ Heart Trouble	☐ Seizures
☐ Cancer	☐ Hepatitis	☐ Tuberculosis
☐ Bleeding Problems	☐ High Blood Pressure	☐ Yellow Jaundice
		☐ Any Venereal Disease

Do you **SMOKE?**
Yes ☐ No ☐ How many packages per day? _____ How many years? _____

Do you consume **ALCOHOLIC** beverages?
Yes ☐ No ☐ How much? _____

Do you have:
Indicate with X if yes

☐ Loose Teeth	☐ Bridges	☐ Chipped Teeth
☐ Caps	☐ Dentures	

Do you have **CONTACT LENSES?**
Yes ☐ No ☐

Have you ever had **CHEST PAIN?**
Yes ☐ No ☐ Please explain _____

Have you had a **COLD** or any **ILLNESS** recently?
Yes ☐ No ☐ Please explain _____

Have you taken any **BLOOD THINNERS** or medication containing **ASPIRIN** within the last two weeks?
Yes ☐ No ☐ Please list _____

Do you **BLEED** easily?
Yes ☐ No ☐ Please explain _____

Patient Identification

_____
SIGNATURE OF PATIENT (or Parent/Legal Guardian) Date