

Surgeries in the past 6 months:		
Procedure	Hospital	Date

Other hospitalizations/surgeries		
Reason	Hospital	Year

List any other medical problems that have not been covered by this form:

Medical Doctor:	Date of last physical exam:
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History	Do you think you bleed longer than normal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, explain		
	Are you currently taking a "blood thinner" such as Plavix, Coumadin, Ticlid or aspirin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had radiation treatments to your head or neck?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have sleep apnea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Tobacco/ Alcohol	Do you smoke? How many packs per day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> # of years <input type="checkbox"/> Chew - # /day <input type="checkbox"/> Pipe - # /day <input type="checkbox"/> Cigars - # /day		
	Do you have a history of drug or alcohol abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Anesthesia	Have you ever had a general anesthetic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had IV sedation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, were there any problems? Explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have a family history of problems with general anesthesia Explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Women Only	Are you pregnant or think you may be pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you taking birth control pills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you aware antibiotics may decrease the effectiveness of birth control pills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Today's Surgery	Do you wear contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If hard lenses, are they out?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Approximate weight? _____		
	Do you presently have a cold or any congestion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If so, can you breathe okay through your nose?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	*****Patients who are going to sleep (general anesthesia)*****		
	Have you had anything at all to eat or drink including water in the last 8 hours?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what? _____ What time? _____		
	Accompanied by someone who can drive you home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

To the best of my knowledge, all of the preceding answers are true and correct. If there are any changes in my health, or if my medicines change, I will inform the doctor.

SIGNATURE	DATE	SIGNATURE OF PARENT OR GUARDIAN	DATE
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