

Please print and fill out this form carefully and completely. Take it to the Sarasota Physicians Surgical Center on the day of surgery.

Procedure: _____ **Height:** _____ **Weight:** _____

Are you allergic to latex? (Please circle and notify the nurse on admission) Yes No

List Other Allergies: _____

List ALL Previous Surgeries: _____

Do you take any blood thinners?

Coumadin	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Stopped when? _____
Plavix	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Stopped when? _____
Aspirin	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Stopped when? _____
Motrin, etc.	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Stopped when? _____
Arthritis med.	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Stopped when? _____

List Below ALL your other medications including over-the-counter, vitamins, & herbal supplements.

Name of Medication	Dose	How taken <small>(by mouth, etc.)</small>	How often	Reason for taking this medication	Last taken?	Leave this column blank
<input type="checkbox"/> Check this box if you do not take any medications					Visit 1	Visit 2

Answer YES or NO for EACH DISEASE

<p>YES NO Cardiovascular Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Arrhythmias or Palpitations</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Failure</p> <p><input type="checkbox"/> <input type="checkbox"/> Valve Disease/Heart Murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Pacemaker/Defibrillator</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of Breath When Climbing Stairs</p> <p>Other: _____</p> <p>YES NO Neurological Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures/Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Mini-Stroke/TIA</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscle Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck/Back Pain</p> <p>Other: _____</p> <p>YES NO Blood Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle Cell Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Clotting/Bleeding Problems</p> <p>YES NO Pediatrics</p> <p><input type="checkbox"/> <input type="checkbox"/> Prematurity</p> <p><input type="checkbox"/> <input type="checkbox"/> Congenital Abnormalities</p> <p>Other: _____</p>	<p>YES NO Pulmonary Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema/COPD</p> <p><input type="checkbox"/> <input type="checkbox"/> Lung Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Bronchitis/Chronic Cough</p> <p><input type="checkbox"/> <input type="checkbox"/> Recent Respiratory Infection</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleep Apnea</p> <p>Other: _____</p> <p>YES NO Endocrine Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes (high blood sugar)</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p>Other: _____</p> <p>YES NO Infectious Diseases</p> <p><input type="checkbox"/> <input type="checkbox"/> MRSA / VRE</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis/Jaundice</p> <p>YES NO GI Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Acid Reflux / GERD</p> <p><input type="checkbox"/> <input type="checkbox"/> Hiatal Hernia</p> <p>Other: _____</p> <p>YES NO Kidney Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Failure</p> <p>Last dialysis: _____</p> <p>Other: _____</p>
---	--

<p>YES NO Substance Use</p> <p><input type="checkbox"/> <input type="checkbox"/> Recreational Drugs</p> <p>Last use? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol</p> <p>Last use? _____</p> <p>Smoking History:</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES _____ Packs / Per day</p> <p style="padding-left: 20px;">_____ Years</p> <p><input type="checkbox"/> QUIT WHEN? _____</p>	<p>YES NO Anesthesia Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficult Intubation</p> <p><input type="checkbox"/> <input type="checkbox"/> Family History of Anesthesia Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Malignant Hyperthermia (You or Your Family)</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty with Jaw Opening</p> <p>Other: _____</p> <p>YES NO Teeth</p> <p><input type="checkbox"/> <input type="checkbox"/> Missing/Loose/Chipped Tooth or Teeth</p> <p><input type="checkbox"/> <input type="checkbox"/> Dentures</p> <p><input type="checkbox"/> <input type="checkbox"/> Fixed Bridge</p> <p>Other: _____</p>	<p>Comments</p> <p>_____</p> <p>_____</p> <p>_____</p>
---	--	---

Visit 1
Reviewed by Doctor _____ Reviewed by CRNA _____

Visit 2
Reviewed by Doctor _____ Reviewed by CRNA _____

Patient Label