Print Form

Preoperative Patient Information

Name: _____

Age: _____ **Height:** _____ **Weight:** _____

Allergies: _____
_____
_____

Previous Anesthesia Complication: **Self No / Yes** _____
Family No / Yes _____

Previous Surgical Procedures: _____
_____
_____
_____
_____
_____

Medical Problems:

High Blood Pressure _____	**Cardiac** _____	**Liver Disease** _____
Respiratory _____	**Valve** _____	**Diabetes** _____
Bleeding Disorder _____	**Urinary** _____	**Cancer** _____
Glacoma _____	**Arthritis** _____	**Vascular** _____
Stroke/TIA _____	**Epilepsy/Seizures** _____	**Emotional/Mental** _____

Comments: _____
_____
_____

Preexisting Infection: _____
Home Meds: _____
_____
_____
_____
_____

What pharmacy do you use? _____

Do You Have:

Dentures/Partials _____	**Glasses/Contacts** _____
Hearing aids _____	**Assistive Device** _____