



**Patient Name:** \_\_\_\_\_ **Date Scheduled for Surgery:** \_\_\_\_\_

**Surgeon:** \_\_\_\_\_ **Procedure:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Patient History**

**Psychological:** (Circle your answer)

Depression/Anxiety/Alzheimer/Bipolar/Claustrophobic Y N

**Metabolic:**

Diabetic: I II High Blood Sugar Y N

Hyper / Hypo Thyroid Y N

**Neuro:**

CVA/Seizure Disorder/Transient Ischemia Y N

Chronic Migraines/HA Y N

Muscular Weakness: Y N

Upper Extremities: Side Right Left

Lower Extremities: Side Right Left

BackPain/NeckPain/Arthritis Y N

**Pulmonary:**

Asthma/COPD/Emphysema Y N

Cough/Dry/Productive Y N

Sleep Apnea / CPAP Y N

**Cardiac:**

Coronary Artery Disease/Heart Attack/High Blood Pressure/Congestive Heart Failure/  
Mitral Valve Prolapse Y N

High Cholesterol Y N

Pacemaker/ICD/Valve Implant Y N

**GI:**

Hiatal Hernia/Gastroesophageal Reflux Disease/Peptic Ulcer Y N

Appetite: Excellent Good Fair Poor

**GU:**

Renal Failure/Dialysis/Chronic Urinary Tract Infection Y N

Infectious Diagnosis /MRSA/TB/Hepatitis Type: \_\_\_\_\_ Y N

Recent Cold/Flu/Upper Respiratory Infection Y N

Blood thinners/Bleeding disorders Y N

Blood Transfusion/Reaction Date \_\_\_\_\_ Y N

Cancer Type: \_\_\_\_\_ Y N

Menopause/Hysterectomy/L.M.C. Date \_\_\_\_\_ Y N