Fairway MEDICAL

PREOP MEDICAL HISTORY

DATE _____

NAME _____ **CELL PHONE#:** _____

PROPOSED OPERATION _____ **HT:**_____**WT:**_____

SURGEON _____

Do you have an **ADVANCE DIRECTIVE/LIVING WILL**? **YES** _____ **NO** _____ (If yes – please bring copy for chart)

Please list your ALLERGIES and REACTIONS

ALLERGY	REACTION

PAST MEDICAL/SURGICAL HISTORY

Primary Care Physician:

_____

Cardiologist:

_____

PLEASE LIST ALL PREVIOUS OPERATIONS OR PROCEDURE /DATE:

1_____/_____ 5 _____/_____

2_____/_____ 6 _____/_____

3_____/_____ 7 _____/_____

4_____/_____ 8 _____/_____

Approximate date of last Anesthetic/Surgery:_____

Have you had any problems with anesthesia? NO_____ YES_____

Have any blood relatives had a serious problem with anesthesia? NO_____ YES_____

Have you taken steroids (Cortisone, Prednisone, Hydrocortisone, or Decadron) within the past 12 months? NO_____ YES_____

REVIEW OF SYSTEMS: DO YOU HAVE A HISTORY OF THE FOLLOWING MEDICAL PROBLEMS?

NO	YES		NO	YES	
_____	_____	Any Heart Studies (EKG, Stress Tests, Angiogram)	_____	_____	Kidney Disease or stones
_____	_____	High Blood Pressure	_____	_____	Diabetes or Hypoglycemia
_____	_____	Chest Pain, Shortness of Breath			If yes, Fasting Blood Sugar _____Range
_____	_____	Heart Attack	_____	_____	Anemia, Easy Bruising, Free Bleeding
_____	_____	Heart Murmur/Irregular Heartbeat	_____	_____	Sickle Cell, Other Blood Disease
_____	_____	Heart Disease, CAD	_____	_____	Epilepsy, Seizures
_____	_____	Elevated Cholesterol, Triglycerides	_____	_____	Fainting or Dizziness
_____	_____	Varicose Veins, Vascular Disorders	_____	_____	Stroke, Paralysis, Other Neuro Disorder
_____	_____	Prev. DVT(blood clot in legs or lungs)	_____	_____	Depression, Anxiety, Psych Disorder
_____	_____	Asthma, Bronchitis, Emphysema, Other Lung Disease	_____	_____	Back Problems, Arthritis, Swelling
_____	_____	Limited Neck Motion, Pain, or Injury	_____	_____	Thyroid Problems, Goiter
_____	_____	Jaw Clicking, Pain or Stiffness	_____	_____	Eye Diseases
_____	_____	Hepatitis, Jaundice, or Liver Disease	_____	_____	Recent Cough, Cold or Flu
_____	_____	Facial Plastic or Reconstructive Surgery	_____	_____	Headaches or Recent Visual Changes
_____	_____	Nausea, Vomiting (Persistent)	_____	_____	Cancer, Immunosuppression, Chemotherapy
_____	_____	Indigestion, Ulcers, Reflux, Hiatal Hernia	_____	_____	Breathing difficulties when lying flat
_____	_____	Ulcerative Colitis, Crohn's Disease, IBS	_____	_____	Sleep Apnea. If yes, CPAP machine used?__
_____	_____	Previous colonoscopy, hx colon polyps, family hx colon cancer	_____	_____	**Family History of Heart Disease**

Other:_____

Do you frequently awaken with numbness in an arm or leg? NO_____ YES_____
Are you Pregnant? NO_____ YES_____ Not Sure_____ Not Applicable_____ Date of last menstrual period_____
Are you Right handed?_____ Left handed?_____
Do you wear contact lenses? NO_____ YES_____ NOTE: If yes, please remove them before surgery.
Do you have Capped Teeth / Crowns_____ Loose Teeth_____ Bridges_____ Dentures/Partials_____
Do you have Advance Directives/ Living Will? NO _____ YES _____ (If YES, please have patient bring copy, if possible)

SOCIAL HISTORY

Occupation:_____ What type of exercise do you get?_____
Do/Did you smoke? NO_____ YES_____ Packs Per Day_____ How many Years?_____ Quit when?_____
What is your alcohol consumption?_____
Do/Did you have a problem with drug or alcohol dependence/addiction?_____
Do you have a religious objection to blood transfusion? NO_____ YES_____

MEDICATIONS

Please list medications, dosage, how often, and when you take your medications

MEDICATION	STRENGTH	FREQUENCY (AM/PM/BOTH)	REASON FOR MED

PATIENT SIGNATURE _____ **VERIFIED BY:**_____**RN** **TIME:**_____

NO ___ **YES**___ **DISCLOSURE ALERT**