Surgical History

Please list any previous surgeries, or spinal injections, and approximate dates of surgery or injections

Surgery Name: Approximate Date:

____________________ ___/___/___
____________________ ___/___/___
____________________ ___/___/___
____________________ ___/___/___
____________________ ___/___/___

Known Allergies to Anesthesia: ☐ Yes ☐ No

Medications

Please list any medications that you currently use, including over-the-counter medications, vitamins, herbs, and prescribed drugs.

Medication Name: ☐ NONE Dosage:

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

Blood Thinners

Please check all Blood Thinners that you are taking:

☐ None Known ☐ Aspirin ☐ Excedrin ☐ Fish Oil / Omega 3 ☐ BC Powder
☐ Pradaxa ☐ Eliquis ☐ Xarelto ☐ Effient ☐ Brilinta
☐ Other:____________________

Family History

Problem:	Does it run in your family?		Family Member(s) who have had this issue:
Diabetes	☐ Yes	☐ No	____________________
Heart Disease	☐ Yes	☐ No	____________________
Asthma	☐ Yes	☐ No	____________________
Blood Clots	☐ Yes	☐ No	____________________
Arthritis	☐ Yes	☐ No	____________________
Hip Problems	☐ Yes	☐ No	____________________
Cancer	☐ Yes	☐ No	____________________

Other: ____________________

Social History

Occupation: Current: ____________________ Past: ____________________
☐ Disabled Reason for Disability: ____________________ ☐ Retired: ____________________
Do you live alone? ☐ Yes ☐ No With whom: ____________________
Do you smoke? ☐ Yes ☐ No ______ packs/day Quit: ______ Months Ago ______ Years Ago
Do you drink alcohol? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently
Any substance abuse? ☐ Yes ☐ No Please List: ____________________

Signatures

Patient Signature: ____________________ Date: ___/___/___
Reviewed by Clinical Staff: ____________________ Date: ___/___/___
Reviewed by Pre-Op Staff: ____________________ Date: ___/___/___