CANE RIVER SURGERY CENTER

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General Surgery
Board Certified by American Board of Surgery

Today's Date:_____

Patient's Personal History

Last Name:_____ First Name:_____ Middle:_____ Age:_____ Date of Birth:_____
Height:_____ Weight:_____ Sex:_____ Marital Status:_____

Past Medical History: *Do you have or your family have?*

Self	Family		Self	Family		Self	Family	
☐	☐	High Blood Pressure	☐	☐	Ulcers, Reflux, Hiatal Hernia	☐	☐	Previous DVT or Blood Clots
☐	☐	Shortness of Breath, Chest Pain	☐	☐	Sickle Cell, Other Blood Disease	☐	☐	Thyroid Problems, Goiter
☐	☐	MI, Murmur, Irregular Heartbeat	☐	☐	Asthma, Bronchitis, Emphysema	☐	☐	Epilepsy, Seizures
☐	☐	Sleep Apnea, CPAP machine	☐	☐	Kidney Disease or Failure	☐	☐	Stiff Neck Motion, Pain/Injury
☐	☐	Anemia, Bruising, Free Bleeding	☐	☐	Recent Cough, Cold, Flu	☐	☐	Jaw Clicking, Pain or Stiffness
☐	☐	Hepatitis, Jaundice, or Liver Disease	☐	☐	Elevated Cholesterol, Triglycerides	☐	☐	Back Problems, Arthritis
☐	☐	Headaches or Recent Visual changes	☐	☐	Stroke,Paralysis, Other Neurological Disorder			
☐	☐	Diabetes or Hypoglycemia	☐	☐	Glaucoma, or Macular Degeneration	☐	☐	Other_____

Past Surgical History:
What surgeries have you had?

_____
_____
_____
_____
_____
_____
_____
_____

Medications/Dosage/Route:

_____
_____
_____
_____
_____
_____
_____
_____

Drug Allergies:

_____ _____

Have you had any problems with anesthesia? ☐ Yes ☐ No
Have any blood relatives had a serious problem with anesthesia? ☐ Yes ☐ No
Have you been taking steroids any time within the last 12 months? ☐ Yes ☐ No
(Cortisone, Prednisone, Hydrocortisone, Decadron) What are you taking?_____
Are you taking aspirin products or blood thinners? ☐ Yes ☐ No
What are you taking?_____

Are you pregnant? ☐ Yes ☐ No ☐ N/A LMP:_____
Do you wear contact lenses? ☐ Yes ☐ No PLEASE REMOVE THEM PRIOR TO SURGERY
Do you have: ( ) Capped Teeth ( ) Crowns ( ) Loose Teeth ( ) Bridges ( ) Dentures ( ) Partials ( ) N/A

Do/did you smoke? ☐ Yes ☐ No How much?_____ How long?_____
Do you drink alcohol? ☐ Yes ☐ No How much?_____
Do you use illegal or recreational drugs? ☐ Yes ☐ No
Do you regularly drink over 6 cups of coffee per day? ☐ Yes ☐ No
Do you have any implants such as pacemaker, cardiac stents or orthopaedic plates & screws? ☐ Yes ☐ No
Date of Last Mammogram (if any)_____ Date of last chest x-ray_____

(Office Use Only)
NPO guidelines discussed with patient ( ) Pt reminded to leave valuables at home( ) Pt instructed to have ride home on premises ( )
Surgery Date:_____ Time of arrival:_____
Nurse Signature:_____ Date_____
Anesthesia Signature:_____ Date_____
Physician Signature:_____ Date_____

Update:_____ Update:_____