

**PRECISION SURGICENTER**

39180 Farwell Drive, Suite 100  
Fremont, CA 94538

Date : \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_

Name \_\_\_\_\_

Previous Operations	When and Where	General	Nerve Block	Spinal/Epidural	Complications?

FAMILY HISTORY OF ANESTHETIC COMPLICATIONS?  NO YES \_\_\_\_\_

DRUG ALLERGIES  NO  YES \_\_\_\_\_

MEDICINES CURRENTLY TAKEN:  NONE  
(includes Vitamins/Herbs/Supplementals)

Medication	Dose	Times Per Day

**Check below if you have or ever have had any of the following:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Kidney Disease/ESRD/Dialysis |
| <input type="checkbox"/> Heart Failure               | <input type="checkbox"/> Bronchitis                 | <input type="checkbox"/> Ulcers/Hiatal Hernia/Reflux  |
| <input type="checkbox"/> Coronary Artery Disease     | <input type="checkbox"/> COPD                       | <input type="checkbox"/> Arthritis                    |
| <input type="checkbox"/> Angina / Chest Pain         | <input type="checkbox"/> Pneumonia                  | <input type="checkbox"/> Back Problems                |
| <input type="checkbox"/> Abnormal ECG                | <input type="checkbox"/> Abnormal Chest X-ray       | <input type="checkbox"/> Steroid/Cortisone            |
| <input type="checkbox"/> Arrhythmia                  | <input type="checkbox"/> Heavy Snoring              | <input type="checkbox"/> Dentures / Partial Plates    |
| <input type="checkbox"/> Murmur / Valve Disease      | <input type="checkbox"/> Sleep Apnea                | <input type="checkbox"/> Capped Teeth                 |
| <input type="checkbox"/> Exercise Limitation         | <input type="checkbox"/> Easy Bruising              | <input type="checkbox"/> Chipped/Loose Teeth          |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Nose Bleeds                | <input type="checkbox"/> Gum Disease                  |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Blood Transfusion          | <input type="checkbox"/> Contact Lenses               |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Glasses                      |
| <input type="checkbox"/> Transient/Ischemic Attack   | <input type="checkbox"/> Hypo / Hyperthyroid        | <input type="checkbox"/> Hearing Aid                  |
| <input type="checkbox"/> Numbness / Weakness         | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Prosthesis                   |
| <input type="checkbox"/> Seizures                    | <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Drug / Substance Abuse       |
| <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Aids / HIV                 | Are you pregnant? Y / N                               |
| <input type="checkbox"/> Psychiatric Illness         | <input type="checkbox"/> Recent Infectious Exposure | Might you be pregnant? Y / N                          |
| <input type="checkbox"/> Motion Sickness / Fainting  | <input type="checkbox"/> Diabetes                   |   |

Other Medical Problems: \_\_\_\_\_

Smoker  Nonsmoker

How many packs do you smoke per day? \_\_\_\_\_ How many Years? \_\_\_\_\_ Quit Date \_\_\_\_\_

Do you drink alcohol?  None  Occasionally  Daily

\_\_\_\_\_  
Patient Signature:

\_\_\_\_\_  
Date

