



Patient Name: _____

Physician: _____

Date of Scheduled Procedure: _____

Medical History

Anesthesia	Hematological	Respiratory
<input type="checkbox"/> HX previous anesthesia	<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma
<input type="checkbox"/> Other	<input type="checkbox"/> Autoimmune Deficiency	<input type="checkbox"/> Bronchitis
Cardiovascular	<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Dialysis	<input type="checkbox"/> COPD
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Influenza
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Previous Blood Transfusion	<input type="checkbox"/> RSV
<input type="checkbox"/> Hypotension	<input type="checkbox"/> Adverse Transfusion Reaction	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> History of Blood Clots	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Other	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Internal Defibrillator	Hepatic	<input type="checkbox"/> Smoking
<input type="checkbox"/> CABG	<input type="checkbox"/> Ascites	<input type="checkbox"/> SOB
<input type="checkbox"/> Heart Cath	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> O2
<input type="checkbox"/> CHF	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Bipap/Cpap
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Other
<input type="checkbox"/> Other	<input type="checkbox"/> Other	Reproductive
EENT	Integumentary	<input type="checkbox"/> GYN Problems
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Skin Disorder	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Earaches	<input type="checkbox"/> Lesions	<input type="checkbox"/> Abortion
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Glasses	Musculoskeletal	Multi Drug Resistant Organisms
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Neck/Jaw Problems	<input type="checkbox"/> Methicillin Resistant Staph A(MRSA)
<input type="checkbox"/> Blind	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Vancomycin Resistant Enterococcus (VRE)
<input type="checkbox"/> Contacts	<input type="checkbox"/> Falls	<input type="checkbox"/> Clostridium Difficile Toxin
Endocrine	<input type="checkbox"/> Amputation	<input type="checkbox"/> Unknown
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	Dental
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Dentures
<input type="checkbox"/> Other	<input type="checkbox"/> Deep Vein Thrombosis	<input type="checkbox"/> Bridge
Gastrointestinal	<input type="checkbox"/> Bed Bound	<input type="checkbox"/> Crowns/Caps
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> WheelChair	<input type="checkbox"/> Chipped/Loose Teeth
<input type="checkbox"/> GI Problems	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Anorexia	Neurological	Other
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Cancer
<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Headaches	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Special Diet	<input type="checkbox"/> Neuromuscular Disorder	<input type="checkbox"/> Infections
<input type="checkbox"/> Gastric Bypass	<input type="checkbox"/> Numbness	<input type="checkbox"/> Measles
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Mumps
<input type="checkbox"/> Obesity	<input type="checkbox"/> Seizures	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Other	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Rubella
Genitourinary	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Other
<input type="checkbox"/> GU Problems	<input type="checkbox"/> Epilepsy	Family History
<input type="checkbox"/> Other	<input type="checkbox"/> Dementia	<input type="checkbox"/> History of Cancer
Hematological	<input type="checkbox"/> Other	<input type="checkbox"/> History of heart disease
<input type="checkbox"/> Anemia	Psychosocial	<input type="checkbox"/> History of Diabetes
<input type="checkbox"/> Autoimmune Deficiency	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Other
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Mental/Emotional Problems	
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Sleep Disorder	
	<input type="checkbox"/> Developmental Delays	
	<input type="checkbox"/> Other	