## SURGICAL PARTNERS OF OKLAHOMA

Name:_____ Date:_____ Age:_____ Weight:_____ Height:_____

Accompanied by:_____ Relationship to patient:_____

### PERSONAL HISTORY: PLEASE CHECK ALL CURRENT OR PAST MEDICAL CONDITIONS

____ Heart trouble
____ Irregular heartbeat
____ High blood pressure
____ Stroke
____ Rheumatic Fever
____ Lung disease
____ Asthma
____ Pneumonia
____ Blood vessel disease (Phlebitis)
____ Jaundice
____ Pancreatits
____ Ulcers
____ Back trouble
____ Muscle weakness
____ Paralysis
____ Epilepsy or seizures
____ Arthritis
____ Glaucoma
____ Blood disease (anemia)
____ Blood tranfusion
____ Sickel Cell trait or disease
____ Kidney disease
____ Dialysis _____days
where_____
____ Urinary problems
date last Tx _____
____ Diabetes
____ Cancer
____ Other medical issue _____
_____
____ Abnormal chest X-ray
____ Abnormal EKG
____ Abnormal bleeding tendencies
____ Anticoagulant therapy
____ NSAIDS
____ Blood thinners or aspirin
____ Positive HIV/AIDS blood test

____ Reaction to tape, bandaids
gloves, balloons, latex
____ Fracture of facial bones
____ Fracture of neck or back
____ Motion sickness
____ Pacemaker
____ Implanted defibrillator
____ Joint replacement
____ Heart Valve replacement
____ Pregnant currently
____ Bronchitis
____ Emphysema
____ Tuberculosis
____ Hepatitis
____ Cirrhosis
____ Gallbladder problems
____ Any abnormal reactions to
anethesia or sedation medication

**Do You Have:**

____ False or loose teeth
____ Dental bridges
____ Glasses or contacts
____ Body piercing
____ Hearing aid

**Do You:**

____ Smoke _____pack(s) per day
____ Drink alcohol
____ Use recreational (street) drugs
List _____
_____
_____

**List allergies (drug, food)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

**List medications & dosages**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

**List prior surgeries & dates**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

**List all Doctors you are currently seeing**

Primary Care _____
Cardiologist _____
Pulmonologist _____
Pain Mgmt _____
Oncologist _____

**Patient Signature** _____