

<p>Are you allergic to any medications, foods, or latex? Yes No</p> <p>Allergy: _____ Reaction: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Respiratory</p> <p>Asthma or Wheezing? Yes No</p> <p>Emphysema or COPD? Yes No</p> <p>Do you have shortness of breath with activity? Yes No</p> <p>Sleep apnea or been told that you have long pauses when you sleep? Yes No</p> <p>Do you use a CPAP machine? Yes No</p> <p>Do you have difficulty breathing while lying flat on your back?? Yes No</p> <p>How many pillows do you sleep on? _____</p> <p>Wear supplemental oxygen? Yes No</p> <p>If yes, how often, how much? _____</p>																																																
<p>Social History</p> <p>Do you currently smoke or use tobacco products? Yes No</p> <p>How many/how often: _____</p> <p>Have you ever smoked? Yes No</p> <p>How long? _____ When did you quit? _____</p> <p>Do you drink alcohol? Yes No</p> <p>If yes, how much, how often? _____</p> <p>Do you or have you used any recreational or "street" drugs? Describe: _____ Yes No</p>	<p>Other</p> <p>Have you been hospitalized in the last 6 months? Yes No</p> <p>Liver problems, cirrhosis or hepatitis? Yes No</p> <p>Thyroid problems? Yes No</p> <p>Kidney failure or dialysis? Yes No</p> <p>Cancer? Yes No</p> <p>Diabetes or high blood sugar? Yes No</p> <p>Blood disease or bleeding problems? Yes No</p> <p>Sickle cell disease? Yes No</p> <p>HIV or AIDS? Yes No</p> <p>Have you been pregnant within the past year? Yes No</p> <p>Are you currently taking an appetite suppressant? Yes No</p> <p>Syndromes or congenital abnormalities? (e.g. Down Syndrome) Yes No</p> <p>Additional Information: _____</p>																																																
<p>CNS/GI</p> <p>Epilepsy or Seizures? Yes No</p> <p>Stroke, Paralysis, TIA, or Meningitis? Yes No</p> <p>Gastroesophageal Reflux (GERD) or heartburn? Yes No</p> <p>Stomach or Intestinal Problems? Yes No</p> <p>Have you had a gastric bypass? Yes No</p> <p>Have you ever had problems with an anesthetic? Yes No</p> <p>*If yes, was it malignant hyperthermia? Yes No</p> <p>Has a blood relative ever had problems with an anesthetic? Yes No</p> <p>*If yes, was it malignant hyperthermia? Yes No</p> <p>Have you ever been told you were a difficult intubation? Yes No</p> <p>Have you ever had nausea and vomiting after anesthesia? Yes No</p>	<p>Primary Care Doctor _____</p> <p>Specialty Doctor _____</p> <p>(Cardiologist, Respiratory, Neurologist, etc.)</p> <p>Pharmacy to Use on Day of Surgery _____</p>																																																
<p>Cardiovascular</p> <p>High Blood Pressure? Yes No</p> <p>Coronary Artery Disease (CAD)? Yes No</p> <p>Heart Attack? Yes No</p> <p>Angina or Chest Pain? Yes No</p> <p>*If yes, describe _____</p> <p>Congestive Heart Failure (CHF) or fluid on the lungs? Yes No</p> <p>Do you have cardiac stents? Yes No</p> <p>*If yes, when were they placed? _____</p> <p>Irregular Heart beat? Yes No</p> <p>Any other heart problems? Yes No</p> <p>*If yes, describe _____</p> <p>Do you see a cardiologist? Yes No</p> <p>*If yes, when was your last visit? _____</p> <p>Do you get shortness of breath when you walk around the grocery store? Yes No</p> <p>Do you need to use a motorized cart? Yes No</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;">Current Medications</th> <th colspan="3">Shaded Section for Nurse Use Only</th> </tr> <tr> <th style="text-align:center;">Drug</th> <th style="text-align:center;">Dose</th> <th style="text-align:center;">Frequency</th> <th style="text-align:center;">Last Dose</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Past Surgical History: (Please list surgery and year) <input type="checkbox"/> N/A</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	Current Medications	Shaded Section for Nurse Use Only			Drug	Dose	Frequency	Last Dose																																								
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<p>Latex Allergy Screening</p> <p>Have you ever had swelling, itching, or hives after contact with a balloon? Yes No</p> <p>Are you allergic to bananas, papaya, avocados, kiwi, tomatoes, potatoes, or chestnuts? Yes No</p> <p>Has a physician ever told you that you have a rubber or latex allergy? Yes No</p>	<p>Nurse Review _____ Date _____</p> <p>(prior to DOS)</p> <p>DOS Nurse Review _____ Date _____</p>																																																