

Name \_\_\_\_\_

Today's date \_\_\_\_\_

Birth date \_\_\_\_\_

**Allergies**

Please list all allergies to medications and your reaction to them.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have an allergy to tape? Yes  No

Latex? Yes  No

**Medications**

Please list all your current medications, vitamins, and herbs that you take regularly.

Medication	Dosage	# times a day	Reason for taking med

Do you take aspirin or drugs that contain aspirin? Yes  No

**Medical diagnoses**

Please list all ongoing health problems for which you see a doctor.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Surgeries and Procedures**

Please list your previous surgeries and procedures and the year that they were done.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check the types of anesthesia that you have received. General  Sedation  Epidural

Have you had any problems with anesthesia in the past? Yes  No

If yes, describe \_\_\_\_\_

Patient / Guardian Signature \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_