THE FOLLOWING DOCUMENTATION MUST BE AVAILABLE AT THE TIME OF BOOKING
FOR PATIENT TO COMPLETE

Patient Name:_____ Date of Birth:_____Gender:_____

Current/Primary Concerns:_____

Are you currently under the care of any other physician? ☐ Yes ☐ No , if yes, please list:

Name:_____ Phone number:_____

Name:_____ Phone number:_____

MEDICAL HISTORY:

Do you have sleep apnea, use CPAP or BiPAP? ☐ Yes ☐ No
Do you have a history of liver disease or chronic cirrhosis? ☐ Yes ☐ No
Do you become short of breath or develop chest pain when climbing two flights of stairs?☐ Yes ☐ No
In the past two years have you required prolonged treatment with steroids? ☐Yes ☐ No
Do you have high blood pressure that requires three or more medications to manage? ☐ Yes ☐ No
Have you ever had a blood clot, stroke, carotid artery blockage, or TIA (mini stroke)? ☐ Yes ☐ No
Are you currently taking blood thinners, such as Coumadin, Plavix, etc.? ☐Yes ☐ No
Do you have diabetes that requires insulin treatment? ☐Yes ☐ No
Do you have problems with excessive bleeding after surgical or dental procedures? ☐Yes ☐ No
Do you have kidney problems (except for kidney stones or recurrent infections) that require treatment by a kidney specialist or are you on dialysis? ☐Yes ☐ No

IMPLANTABLE DEVICE(S): ☐ No ☐ Yes, indicate type of device(s):

☐Pacemaker/Defibrillator Year:	☐Cardiac stent Year:	☐Ventricular Assist Device Year:	☐Insulin Pump Year:	☐Other

SURGICAL HISTORY: ☐ No ☐ Yes, list surgeries:

Year:	Type of Surgery/Procedure	Describe any Anesthetic Complications *(other than Nausea or Vomiting)*

MEDICATIONS: ☐ Not taking medication ☐ Yes, Please list all medications prescribed and over the counter

Medication	Dose	Frequency	Medication	Dose	Frequency
1			5		
2			6		
3			7		
4			8		