FULL NAME **Age:** **(Date Revised _____)**

D.O.B. **Occupation:**
Address: **Marital Status:**
Phone: **Sex:**
SS # **Height :**
Insurance: **Weight :**
Secondary Ins: **BMI:**
Rx Plan: **Blood Type :**

PRIMARY PHYSICIAN & Contact Numbers

-

OTHER (current) ATTENDING PHYSICIANS / SPECIALISTS & Contact Numbers

-
-
-

EMERGENCY CONTACTS: (Note which contacts have DPOA for medical decisions)

-
-
-

DRUG ALLERGIES:

-
-

OTHER ALLERGIES: (i.e. latex, food allergies, etc.)

Social:

Tobacco Use: _____Yes _____No ____Packs per day x _____ # of Years
ETOH: (alcohol) _____ Drinks / Beers Per Day
Cannabis Use: _____ Smoke (Times per day ___)
_____ Edible (Times per day ___)

Medical History: (Past & Current Conditions & if resolved or under control)

-
-
-

Surgical History: (Date, Procedure, Successful? Any Complications?)

Date -
Date -
Date -

Continued on next page…..

FULL NAME
D.O.B.

Previous Anesthesia Complications:

Family History of Anesthesia Complications:

Family Medical History of Significance:

Prescription Medications: (Name, Dosage & Condition being treated)

-
-
-

PRN Prescription Medications:

-
-

OTC Supplements: (Vitamins, herbs, snake oils)

-
-
-

Immunizations & Dates

-
-
-

ADDITIONAL INFORMATION OR COMMENTS:

Note if you have had any **medical genetic testing**, and provide copies of the results in this packet.

Are you absent any major organs? Is it a congenital absence? Surgically removed? Have you donated an organ?

Note if you are an **organ recipient.**

Continued on next page…...

FULL NAME
D.O.B.

Note if any of these apply (location, type, etc):

- Eyeglasses / Contacts
- Hearing Aids
- Prosthetic Eye
- Dentures
- Dental caps, crowns or veneers
- Surgical plates and/or screws
- Total Joint Replacements
- Exotic Piercings
- Penile Prosthesis
- Pacemaker (What type?)