

What are you seeing Dr. Knight for today: _____
How did you hear about Dr. Knight: _____

Patient's Personal History

Last Name: _____ First Name: _____ Middle: _____ Age: _____ Date of Birth: _____
Height: _____ Weight: _____ Sex: _____ Marital Status: _____

Past Medical History: Do you have?

- | Self | Family | | Self | Family | | Self | Family | |
|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers, Reflux, Hiatal Hernia | <input type="checkbox"/> | <input type="checkbox"/> | Previous DVT or Blood Clots |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath, Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell, Other Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems, Goiter |
| <input type="checkbox"/> | <input type="checkbox"/> | MI, Murmur, Irregular Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, Bronchitis, Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy, Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea, CPAP machine | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease or Failure | <input type="checkbox"/> | <input type="checkbox"/> | Stiff Neck Motion, Pain/Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia, Bruising, Free Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Recent Cough, Cold, Flu | <input type="checkbox"/> | <input type="checkbox"/> | Jaw Clicking, Pain or Stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, Jaundice, or Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Elevated Cholesterol, Triglycerides | <input type="checkbox"/> | <input type="checkbox"/> | Back Problems, Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches or Recent Visual changes | <input type="checkbox"/> | <input type="checkbox"/> | Stroke, Paralysis, Other Neurological Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma, or Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | |

Past Surgical History:

What surgeries have you had?

Medications/Dosage/Route:

Drug Allergies:

- Have you had any problems with anesthesia? Yes No
Have any blood relatives had a serious problem with anesthesia? Yes No
Have you been taking steroids any time within the last 12 months?
(Cortisone, Prednisone, Hydrocortisone, Decadron) What are you taking? _____
Are you taking aspirin products or blood thinners? Yes No
What are you taking? _____

- Are you pregnant? Yes No N/A LMP: _____
Do you wear contact lenses? Yes No PLEASE REMOVE THEM PRIOR TO SURGERY
Do you have: () Capped Teeth () Crowns () Loose Teeth () Bridges () Dentures () Partials () N/A

- Do/did you smoke? Yes No How much? _____ How long? _____
Do you drink alcohol? Yes No How much? _____
Do you use illegal or recreational drugs? Yes No
Do you regularly drink over 6 cups of coffee per day? Yes No
Do you have any implants such as pacemaker, cardiac stents or orthopaedic plates & screws? Yes No
Date of Last Mammogram (if any) _____ Date of last chest x-ray _____

NPO guidelines discussed with patient () Pt reminded to leave valuables at home () Pt instructed to have ride home on premises ()

Surgery Date: _____ Time of arrival: _____
Nurse Signature: _____ Date _____
Anesthesia Signature: _____ Date _____
Physician Signature: _____ Date _____

Update: _____ Update: _____