



Medical Information Database/Pre-Op Assessment

Name _____ Date _____

Date of Birth _____

Reason for seeing physician _____

Referring Physician _____ Were you seen in the E.R.? YES / NO

If YES, which hospital _____ Date of accident or injury _____

Primary Care Provider, Pediatrician, Family Doctor, and GYN, if you have one

Previous Medical History

Do you have a latex allergy/sensitivity? YES / NO

If YES, what type of reaction _____

List all known drug allergies

List all medications you are taking (OTC and prescribed) and the reasons. Include dose and frequency.

List any weight loss medications

List any medications you cannot take

Preferred Pharmacy _____

Height and Weight _____ BMI _____

Immunizations

Please indicate the date (month and year) of last immunization.

Tetanus Booster _____

Chicken Pox _____

DPT _____

Hepatitis B _____

MMR _____

Polio _____

Covid-19 Dose 1 _____

Covid-19 Dose 2 _____

Covid-19 Booster _____

Shingrix _____

Updated and Effective: September 2026



Current Medical Problems

YES NO

☐ ☐ High Blood Pressure
☐ ☐ Cancer
☐ ☐ Immune Deficiency
☐ ☐ Lung Disease
☐ ☐ HIV/AIDS
☐ ☐ Breast Disease

YES NO

☐ ☐ Cardiac Disease/Heart Attack
☐ ☐ Diabetes
☐ ☐ Kidney Disease
☐ ☐ Substance Abuse
☐ ☐ Hepatitis A/B/C
☐ ☐ DVT/PE

Review of Systems

YES NO

☐ ☐ Fever
☐ ☐ Sinusitis
☐ ☐ Seizures
☐ ☐ Skin lesions that are changing
☐ ☐ Excessive bleeding/easy bruising
☐ ☐ Corrective lenses (glasses, contacts)
☐ ☐ Shortness of breath
☐ ☐ Sleep Apnea
☐ ☐ Diarrhea
☐ ☐ Jaundice
☐ ☐ Earaches
☐ ☐ Heartburn
☐ ☐ Blood in bowel movements
☐ ☐ Depression or anxiety

YES NO

☐ ☐ Vision Problems
☐ ☐ Chest Pain
☐ ☐ Constipation
☐ ☐ Coughing up blood
☐ ☐ Chills
☐ ☐ Sore Throat
☐ ☐ Weakness/numbness
☐ ☐ Reflux
☐ ☐ Blood in urine
☐ ☐ Weight loss or gain
☐ ☐ Wheezing/asthma
☐ ☐ Fainting
☐ ☐ Difficulty urinating
☐ ☐ Difficulty healing

Have you tested positive for Covid-19 within the past year? YES NO

If YES, when was your most recent positive Covid-19 test? _____

Previous Hospitalizations/Pregnancies

Date (month/year)	Reason for Hospitalization	Difficulty with Anesthesia
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO



Past Surgical History

Date (month/year)	Surgical Procedure	Difficulty with Anesthesia	
		YES	NO
_____	_____	YES	NO
_____	_____	YES	NO
_____	_____	YES	NO
_____	_____	YES	NO

Would you object to a medically necessary blood transfusion? **YES** **NO**

Last menstrual period _____ Any chance of being pregnant _____

Social History

Do you use tobacco/nicotine products of any kind? (Ex. Vapes, Cigarettes, Zyn, chewing tobacco, e-cigarettes, nicotine gum, nicotine patch) **YES** **NO** Amount/frequency _____

Do you drink alcohol? **YES** **NO** Amount/frequency _____

Do you use illegal drugs? **YES** **NO** Amount/frequency _____

Occupation _____

Living Situation (who is living in your household) _____

Family History

	YES	NO	Relationship
High Blood Pressure	_____	_____	_____
Diabetes	_____	_____	_____
Breast Cancer	_____	_____	_____
Melanoma	_____	_____	_____
Other Cancers	_____	_____	_____
DVT/PE	_____	_____	_____
Medullary Thyroid Cancer	_____	_____	_____

Date of most recent lab work, EKG, x-ray, or diagnostic test _____

Location _____ Phone _____

Please list the two most important questions we can answer for you at your initial consultation:



TO BE COMPLETED BY OFFICE STAFF:

Pre-Operative

____ CBC

____ CXR

____ BMP

____ EKG

____ H&H

____ Other:

____ PT

____ PTT

Orders Mailed to Patient: _____

____ UA Pregnancy

Orders Given to Patient: _____

Reviewed on _____ by _____

Reviewed and updated on _____ by _____

*Instructed patient to fax results to surgery center? YES NO

Pre-Operative assessment completed by _____

Date _____

Anesthesia reviewed by _____

Date _____

Patient is approved for outpatient surgery? YES NO

ASA I ASA II ASA III (only with anesthesia consultation)