Magnolia
SURGERY CENTER

MEDICAL HISTORY

1. Have you been hospitalized in the last 6 months? _____ Yes No
2. LIST ALL PREVIOUS SURGERIES _____

_____

3. a. Any anesthesia complications? _____ Yes No
   b. Any family history of anesthetic problems? _____ Yes No
4. Any bleeding disorders or taking blood thinners? _____ Yes No
5. A cold within the last two weeks? _____ Yes No
6. Heart problems? _____ Yes No
   Heart attack? _____ Yes No
7. High blood pressure? _____ Yes No
8. Shortness of breath? _____ Yes No
   a. Asthma? _____ Yes No
   b. Emphysema? _____ Yes No
   c. Chronic cough/bronchitis? _____ Yes No
9. Do you smoke or have you ever smoked? _____ Yes No
   How much? _____ Date quit: _____
10. Jaundice or hepatitis? _____ Yes No
11. Kidney failure? _____ Yes No
12. Ulcers, heartburn, or hiatal hernia? _____ Yes No
13. Diabetes? _____ Yes No
14. Arthritis? _____ Yes No
15. Stroke or convulsion? _____ Yes No
16. Blood clot or a circulatory problem? _____ Yes No
17. Do you drink alcohol? How much? _____ Yes No
18. Do you use drugs such as cocaine, heroin, speed? _____ Yes No
19. Have you been diagnosed with AIDS? _____ Yes No
20. Have you ever had Tuberculosis (T.B.)? _____ Yes No
21. Sleep apnea? _____ Yes No
22. Latex allergy? _____ Yes No
23. Other unusual health problems or diagnoses? _____ Yes No

CURRENT MEDICATIONS: _____

_____

Took circled Meds ☐ Took no Meds ☐

ALLERGIES: _____

Do you have any loose or removable teeth? _____ Yes No

What time did you last eat or drink? _____ Date: _____