Patient Sticker Here
Name
DOS

CAMPUS SURGERY CENTER

901 Campus Drive, Suite 102 ♦ Daly City, California 94015 ♦ (650) 991-2000 ♦ FAX (408) 402-7016

PAIN MEDICINE PATIENT HEALTH HISTORY

NAME_____ AGE_____ SEX ☐ Male ☐ Female

HEIGHT ____ ft _____ in WEIGHT _____ lbs MEDICAL DOCTOR_____

PAST SURGERIES TYPE OF ANESTHESIA DATE (YEAR)

_____
_____
_____
_____
_____
_____
_____

Did you or your family ever have any problems with any anesthetics?

Did you **EVER** smoke? ☐ yes ☐ no, If **YES**, what age did you start smoking? _____ years old.
How much did you smoke on a regular basis? _____ packs per day. If you quit, when did you quit? ___years ago.

Do you drink alcohol? ☐ yes ☐ no, If **YES**, how much can you drink without feeling a little drunk?
_____ cans of beer or _____ glasses of wine or _____ cocktails.

Do you presently use any recreational drugs? ☐ yes ☐ no, If **YES**, please list _____

If you are a woman, is there ***ANY*** chance you may be pregnant? ☐ yes ☐ no

Significant medical history: Mark an **X** for any condition that you have had personally (not just in family).

strokes ☐ nerve disease ☐ peripheral neuropathy ☐
osteoarthritis ☐ rheumatoid ☐ gout ☐
neck pain ☐ back pain ☐ sciatica ☐
anxiety ☐ depression ☐ insomnia ☐
sinusitis, allergic rhinitis ☐
asthma ☐ sleep apnea ☐
recent cold, flu or sore throat ☐
gastritis or ulcer ☐ hiatal hernia ☐
hepatitis or jaundice ☐

high cholesterol or lipids ☐
irregular heart beats, palpitations ☐
heart attack ☐ heart failure ☐ angina (cardiac) ☐
high blood pressure ☐
diabetes ☐
kidney disease ☐ bladder infections ☐
anemia ☐ bleed easily ☐ bruise easily ☐
sickle cell disease or trait ☐
NONE OF THE ABOVE ☐

Do you have any other medical problems or information you wish us to know about you?

_____
_____
_____

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LIST OF MEDICATIONS Note: Please leave shaded areas blank

Allergies: (Include all drugs, foods, and environmental allergies)

☐ No known allergies

Allergy	Type of Reaction	Allergy	Type of Reaction
		☐ N ☐ Y Latex Allergy	
		☐ N ☐ Y Iodine Allergy	

Medications: (Include all prescriptions, over-the counter medicines, supplements, and herbs)

☐ No current medications

Current Prescription Medications:	Dose	Last Dose Taken/Time	How Often	Stop After Discharge
Herbals, Vitamins, Supplements, Non-Rx Drugs	**Dose**	**Last Dose Taken/Time**	**How Often**	**Stop After Discharge**

☐ For additional Medications see separate sheet

Patient/Responsible Person Signature: _____Date: _____

☐ NA New Medications or New Dosages for After Discharge	Dose	How Often

Patient/Responsible Person Signature: _____ Date: _____

Discharge Nurse Signature: _____ Date: _____

Resume Pre-Operative Medications as directed by the prescribing Physician. Any Medications that need to be stopped after discharge are noted above.

Practitioner's Signature: _____ **Date:** _____