SAS Adult Medical History

Date_______________

Patient's Full Name ____
DOB____/____/______ Age __________
Gender: □ M □ F Height _______ Weight: _______ lb or kg (Please circle)

Name/address/phone of primary physician ____
Date of last appt________________
Name/address/phone of medical specialists:
____

1) Are you being treated by a physician at this time? Reason ____ □ Yes □ No
2) Have you been ill in the past 6 weeks? Describe ____ □ Yes □ No
3) Are you taking any medication (prescription or over-the-counter), vitamins, or dietary supplements? □ Yes □ No
List name, dose, frequency, and date started: ____(use back if needed)
4) Have you ever been hospitalized, had surgery or significant injury, or been treated in an ER? □ Yes □ No
List date and describe: ____
5) Have you, or family members, ever had a reaction to or problem with an anesthetic? □ Yes □ No
Describe: ____
6) Have you ever had a reaction or allergy to an antibiotic, sedative, or other medication? □ Yes □ No
List ____
7) Are you allergic to latex or anything else, such as metals, acrylic, dyes, or foods? Soy allergy? □ Yes □ No
List ____

Please mark YES if you have a history of the following conditions. For each "Yes", provide details at the end of this form.
Mark NO after each line if the conditions do not apply to you.

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8) Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions .. □ Yes □ No
9) Disorders, learning problems/delays, or intellectual disability ………………………………………….. □ Yes □ No

10) Sinusitis, chronic adenoid/tonsil infections ……………………………………………………………… □ Yes □ No
11) Sleep apnea/snoring, mouth breathing, or excessive gagging …………………………………………… □ Yes □ No

12) Heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease …………………….. □ Yes □ No
13) Irregular heart beat or high blood pressure ……………………………………………………………… □ Yes □ No
14) Shortness of breath, chest pain, dyspnea on exertion, coronary artery disease or stents, stroke,
pacemaker/defribillator? ……………………………………………………………………………………… □ Yes □ No

15) Asthma, reactive airway disease, wheezing, or breathing problems ……………………………………... □ Yes □ No
16) Cystic fibrosis …………………………………………………………………………………………………… □ Yes □ No
17) Frequent colds or coughs, or pneumonia ………………………………………………………………… □ Yes □ No
18) Do you smoke, vape, or use any other tobacco products? How much per week?……………………… □ Yes □ No

19) Jaundice, hepatitis, or liver problems …………………………………………………………………… □ Yes □ No
20) Do you drink alcohol? If so, how much per week? …………………………………...………………… □ Yes □ No
21) Do you use recreational drugs? (what type? how often?) ……………………………………………… □ Yes □ No
22) Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ………………… □ Yes □ No
23) Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions …………………….. □ Yes □ No
24) Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder …………….. □ Yes □ No

25) Bladder or kidney problems ……………………………………………………………………………….. □ Yes □ No

26) Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems ……………………… □ Yes □ No

27) Rash/hives, eczema, or skin problems …………………………………………………………………… □ Yes □ No

28) Impaired vision, hearing, or speech .... □ Yes □ No
29) Cerebral palsy, brain injury, epilepsy, or convulsions/seizures .... □ Yes □ No
30) Autism/autism spectrum disorder, Down Syndrome, MR, or other diagnoses .... □ Yes □ No
31) Recurrent or frequent headaches/migraines, fainting, or dizziness .... □ Yes □ No
32) Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)....... □ Yes □ No

33) Attention deficit/hyperactivity disorder (ADD/ADHD) .... □ Yes □ No
34) Behavioral, emotional, communication, or psychiatric problems/treatment .... □ Yes □ No
35) Abuse (physical, psychological, emotional, or sexual) or neglect .... □ Yes □ No

36) Diabetes, hyperglycemia, or hypoglycemia .... □ Yes □ No
37) Hormonal problems .... □ Yes □ No
38) Thyroid or pituitary problems .... □ Yes □ No

39) Anemia, sickle cell disease/trait, or blood disorder .... □ Yes □ No
40) Hemophilia, bruising easily, or excessive bleeding .... □ Yes □ No
41) Transfusions or receiving blood products .... □ Yes □ No
42) Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow/organ transplant □ Yes □ No

43) Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV/AIDS) .... □ Yes □ No

PROVIDE DETAILS HERE: ____

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Is there any other significant medical history **pertaining to you or your family** that we should know? □ Yes □ No

Describe:

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Patient Instruction Sheet - Adult

You will be receiving intravenous medications during your operative procedure. It is therefore very important that you adhere to the following instructions. If there are any questions, please don't hesitate to call for further directions: (316) 788-5939.

If you have a prescription for breathing treatments, please bring your inhaler the day of the procedure.

1) No food for **eight hours** prior to your procedure. You may have **clear** liquids (doesn't include milk) up to **three hours** prior to your procedure. Once in the 3-hr window before your appointment, absolutely nothing in the mouth (do not even brush teeth).

2) Wear comfortable clothing, preferably a shirt or blouse with short sleeves. It is suggested you wear an adult *Depends*/brief or bring a change of clothing as a precaution for possible bladder leakage, as sometimes occurs with sedation.

3) Remove fingernail polish from at least one fingernail on each hand.

4) Arrange for transportation from surgeon's office to your home.

5) After your surgery, wait until the next day before engaging in any activity in which a decrease in alertness, judgement, or coordination could cause a problem (including driving).

6) After surgery, you may take pain medication as directed by the surgeon. However, avoid alcohol post-operatively for 24 hours.

7) Arrange for adult assistance for at least 12 hours after surgery.

I have read the above instructions, they are clear to me, and I agree to comply.

______________________________	______________________________
Patient	Signature of patient or responsible party

Please fax or send the completed forms to our office as soon as possible prior to the date of service. Your cooperation will enhance the safety of this procedure and is greatly appreciated.