



Medical History Form - Adult

This form is to be completed and returned to our office at least two weeks prior to the day of your surgery. All information is essential to insure your comfort and safety for a procedure requiring the administration of intravenous medications. All information will be held in the strictest of confidence, and will become a permanent part of the surgeon's office records. None of this information will be released without written permission from you. If you need additional space for your answers, please use the back of this form. Please circle the appropriate letter below.

	<u>Yes</u>	<u>No</u>
1) Please list all past surgeries and approximate year they were performed. _____		
2) Have you or anyone in your family ever had a problem with an anesthetic? ----- If so, explain. _____	Y	N
3) Any allergies, sensitivities, or adverse reactions to any medications? ----- If so, explain. _____	Y	N
4) List all medications which you are currently taking. _____		
5) Do you have a history of heart problems (including angina, heart attack, congestive heart failure, valve disease, murmur, pacemaker, or arrhythmia)? ----- If so, explain. _____	Y	N
6) Do you have high blood pressure? -----	Y	N
7) Have you ever had a stroke? ----- If so, state when, and any residual effects. _____	Y	N
8) Have you ever been diagnosed as having a lung disease (incl. asthma, emphysema, TB, pneumonia, etc.)? ----- If so, explain. _____	Y	N
9) Do you smoke? ----- If so, how many packs a day, and for how many years? _____	Y	N
10) Have you had a recent cold or cough? -----	Y	N
11) Do you have a history of kidney disease? ----- If so, explain. _____	Y	N
12) Do you have a history of liver disease (hepatitis, jaundice, etc.)? -----	Y	N
13) To your knowledge, have you ever been exposed to the HIV virus? -----	Y	N
14) Do you have a history of diabetes or hypoglycemia (low blood sugar)? ----- If so, explain. _____	Y	N
15) Do you have a history of thyroid problems? ----- If so, explain. _____	Y	N
16) Do you drink alcohol or use drugs socially or recreationally? ----- If so, list type(s) and amount. _____	Y	N
17) Are there any other medical problems which you feel we should know about? ----- If so, explain. _____	Y	N

The above questions have been answered fully and to the best of my knowledge.

Signature of patient or responsible party: _____



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.

- 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.
- 2) Wear comfortable clothing , preferably a shirt or blouse with short sleeves.
- 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 bring this form with you to the surgeon's office on the day of surgery. Your cooperation will enhance the safety of this procedure, and is greatly appreciated.