Patient Name_____ **Date**_____

1.) Are you currently taking aspirin? Yes_____ No_____ Please list all medications you are currently taking, including supplements:

2.) Drug Allergies

3.) Have you or a family member ever had problems with anesthesia? Yes____ No____ Comments_____

4.) Are you currently being treated for any of the following conditions?

Obstructive sleep apnea Yes_____ No_____ Diabetes Yes_____ No_____ High blood pressure Yes_____ No_____

Cancer Yes_____ No_____ Heart disease Yes_____ No_____ Lung problems Yes_____ No_____ Allergies Yes_____ No_____

Stomach problems Yes_____ No_____ Other (please list) _____

5.) Are you allergic to latex? Yes_____ No_____ Are you allergic to the dye used for some imaging tests? Yes_____ No_____

6.) Are you currently using or have you ever used a CPAP machine? Yes_____ No_____ Comments_____

7.) Is there a family history of:

Diabetes Yes_____ No_____ Bleeding disorder Yes_____ No_____ Cancer Yes_____ No_____

Heart disease Yes_____ No_____ Stroke Yes_____ No_____ Hearing loss Yes_____ No_____

8.) Have you ever been admitted to a hospital? Yes_____ No_____ If yes, list approximate dates and reason for hospitalization.

9.) Have you ever had surgery? Yes_____ No_____ If yes, list approximate date and type of surgery.

10.) Do you currently smoke or use smokeless tobacco? Yes_____ No_____ If yes, how many packs per day? _____

11.) How long have you smoked or used smokeless tobacco? _____

12.) If no, have you ever smoked in the past? Yes____ No____ If yes, how many years? _____ When did you quit smoking? _____

13.) Do you drink alcohol? Yes_____ No_____ If yes, how often and how much do you drink? _____