Waverly Lake
SURGERY CENTER

Patient Pre-Operative Health History

Date __________ Name ________________________________ **DOB** ___________ **Sex** M/F **Ht**______ **Wt** ______

Allergies: ☐ Yes (please list below) ☐ None ☐ Covid vaccinated [If so, please bring record to appt.]

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Medications: ☐ Yes, please add on back ☐ Yes, Medication List Attached ☐ None

ANESTHESIA Past anesthetic complications ☐ Yes (please explain) ☐ No

Family history of anesthesia complications ☐ Yes (please explain) ☐ No

Explanation____

☐ Post-operative nausea/vomiting ☐ Motion Sickness

CARDIOVASCULAR ☐ No issues or problems OTHER____

☐ High Blood Pressure ☐ Heart Murmur ☐ Abnormal Heart Rhythm *(*ex: AFIB) ☐ Chest Pain ☐ Bypass ☐ Stent

☐ Coronary Artery/ Heart Disease ☐ Congestive Heart Failure ☐ Heart Attack/date_______ ☐ Pacemaker/Defib.

RESPIRATORY ☐ No issues or problems OTHER____

☐ COPD/ Emphysema ☐ Asthma ☐ Recent Cough/Cold ☐ Bronchitis/Pneumonia ☐ Sleep Apnea ☐ CPAP/BIPAP

☐ SOB With Exertion ☐ SOB at Rest ☐ TB ☐ O2 use How often [Night? Continuous?] ___________ Liters_______

☐ Smoker ☐ Current/Former Stop Date___________ Tobacco Type ________________ Frequency _____________

NEUROLOGIC ☐ No issues or problems OTHER____

☐ Seizure Hx ☐ Epilepsy ☐ Neuromuscular disease ☐ Stroke/TIA [date]________ Residuals____________________

GASTROINTESTINAL ☐ No issues or problems OTHER____

☐ GERD ☐ Indigestion ☐ Hiatal Hernia ☐ Bleeding Ulcer ☐ Cirrhosis ☐ Jaundice ☐ Hepatitis

ENDOCRINE ☐ No issues or problems OTHER____

☐ Thyroid disease ☐ Diabetes ☐ Type I ☐ Type II ☐ Insulin dependent

RENAL ☐ No issues or problems OTHER____

☐ Chronic Kidney Disease Stage_____________ ☐ Dialysis Days/Week____________ Last visit ____________

HEMATOLOGY/ONCOLOGY ☐ No issues or problems OTHER____

☐ Anemia ☐ Bleeding disorder ☐ Clotting Disorder ☐ DVT/Pulmonary Embolism ☐ Leukemia ☐ HIV

MUSCULOSKELETAL ☐ No issues or problems OTHER____

☐ Neck/Back ☐ Weakness? Numbness? Tingling? Location__________ ☐ TMJ ☐ Rheumatoid Arthritis/ Fibromyalgia

MOOD ☐ No issues or problems OTHER____

☐ Anxiety ☐ Depression ☐ Bipolar ☐ PTSD

OTHER ☐ No issues or problems ☐ Anything more to add? ______________________________________

☐ Alcohol ________ day/wk/mo ☐ Recreational drug use Type _____________ ☐ Hysterectomy/ Tubal Ligation

☐ Current/ Recent Infection [ex. UTI, COVID, FLU] Date _______________ Diagnosis __________________________

☐ Current or history of MRSA/VRE/OTHER ☐ Auto Immune Disease ______________ ☐ Chemo/Radiation

Current Medication List

Name ____ DOB ________________________ Date _______________

Medication	Dosage	Frequency