Beacon Orthopaedics Surgery Center
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Patient_____ **D.O.B.**_____
Surgery date_____ _____
Surgical Procedure_____
_____

	Medical History	**Assessment**				**Previous Surgery YES □ NO □**
		Sys	**NOR**	**ABN**	**Comments**	List:
	Circle if Applicable					
1	Cold / Chronic Cough / Tuberculosis	HEENT				
2	Bronchitis / Emphysema/ OSA					
3	Asthma / Shortness of Breath	NECK				
4	Rheumatic Fever / Heart Murmur					
5	High Blood Pressure	CHEST				
6	Swelling of Feet / Fluid in Lungs					
7	Heart Attack	HEART				**Allergies YES □ NO □**
8	Irregular, Fast Heartbeats					List:
9	Bruises, Bleeding Easily	ABDOMEN				
10	Sickle Cell Anemia / Anemia					
11	Diabetic / Low Blood Sugar	EXTREM.				
12	Pregnant: No.of weeks _____					
13	Kidney Disease	**M.D. Notes**				**Medications YES □ NO □**
14	Jaundice / Hepatitis					List:
15	Hiatal Hernia / Ulcer/ GERD					
16	Convulsioins / Epilepsy / Stroke					
17	Meningitis / Paralysis					
18	Back Pain / Slipped Disc / Arthritis					
19	Psychological Disease					
20	Thyroid Disease					
21	Glaucoma					
22	Skeletal Deformities/ Disease					
23	Loose Teeth / Caps on Front Teeth					
24	History Anesthesia Complications					
	Self / Family					
25	Cancer / Leukemia / HIV	**** K if on Diuretics***				
Smoker : Pack / Day		**** EKG needed for 50 or older or***				**Family History:**
Alcohol intake:		***cardiac history***				
Drug Abuse:						
Menstrual History:						
Menopause:						
Hysterectomy:						
LMP		***Patient is medically cleared for surgery***				
VS		YES □ NO □				
Height						
Weight		**Physician's Signature/ Date**				