Patient Sticker

Wisconsin Surgery Center
Patient History

Patient Name: _____ DOB: _____

MEDICATION ALLERGIES: _____

LATEX ALLERGY ☐ Y ☐ N

IODINE or IVP DYE ALLERGY ☐ Y ☐ N

No Known Drug Allergies ☐

Check (✔) conditions you currently have or have had in the past

Do you have or have you had a history of:

- ☐ AIDS/ HIV positive
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Cancer What kind? _____
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/ Seizures
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Glaucomal Cataracts
- ☐ Gout
- ☐ Hepatitis What kind? _____
- ☐ Herpes What kind? _____
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Malignant Hyperthermia/Family HIO Malignant Hyperthermia
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Pacemaker/ICD (defibrillator)
- ☐ Pain/ numbness/tingling
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis

Other: _____

_____

_____

CARDIOVASCULAR

- ☐ CABG
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Irregular beat
- ☐ Low Blood Pressure
- ☐ Murmur
- ☐ Poor circulation
- ☐ Rapid Heart Rate
- ☐ Swelling of ankles

GASTROINTESTINAL

- ☐ Abd. Pain
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ GERD
- ☐ IBS, Crohns, Colitis
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Vomiting/ vomiting blood

GYN

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Extreme menstrual pain
- ☐ Hot Flashes

Date of last menstrual period _____

Are you pregnant? _____

Number of Children _____

Any pregnancy complications? _____

SUBSTANCE USE:

- ☐ Caffeine How much? _____
- ☐ Tobacco How much? _____
- ☐ Alcohol How much? _____
- ☐ Street drugs How much? _____

Which kinds? _____

Have you every had a blood

transfusion? _____

What year? _____

Ht:: _____

Wt: _____

Do you have a Power of Attorney or a Living Will?

☐ Y ☐ N

Complete back side also)

HOSPITALIZATION / SURGERIES	
YEAR	**Reason for hospitalization and prior surgeries**

☐ No problems with anesthesia

☐ Problems with anesthesia. EXPLAIN: _____

_____

_____

_____

I certify that the above Information Is correct to the beat of my knowledge. I will not hold my doctor or any member of hlelher staff responsible for any errors or omissions that I may have made In completion of this form.

Signature _____ Date _____

Reviewed by (RN) _____ Date _____ Time _____

WISCONSIN SURGERY CENTER
MEDICATION LIST

Patient Name: _____

MEDICATION ALLERGIES: _____

Medication	Dosage	Frequency