



Pre-surgical Consultation/ Medical History

Name: _____ Date: _____ Last Menses: _____

Age _____ Pregnancies: _____ Children: _____ Current birth control: _____

Other physicians that you see: _____

Medication Allergies – Reactions: _____

Do you have a Latex allergy? No Yes Unknown

Do you have a problem with anesthesia? No Yes What is it? _____

Current Medications: (list all with dose) _____

Previous Surgeries – Year (include C-Sections)

Other Hospitalizations - Year

Any ongoing Medical Problems - high blood pressure, high cholesterol, diabetes, asthma, heart burn

Family History:

Relative Birth Year Living Medical Problems

Mother

Father

Siblings

Do any family members have the following problems? Diabetes, High Blood Pressure, Problems with anesthesia, Cancer (list type), Stroke, Heart _____

Los Olivos info:

Date of Surgery: _____ Time: _____ Place: GSH LGSC SVSC

Consent to read: _____

Last Pap: _____ Height: _____ Weight: _____ BP: _____

Blood type (if known): _____ Misoprostel No Yes Consents to pt: Hyst Consent Faxed