LOS OLIVOS
WOMEN'S MEDICAL GROUP
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www.lowmg.com

Pre-surgical Consultation/ Medical History

Please leave blank any category that doesn't apply – Complete this for your appointment.

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

_____
_____
_____
_____
_____
_____

Ongoing Medical Problems (such as 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 □