

## 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 _____ _____ _____ _____ _____
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Ongoing Medical Problems (such as high blood pressure, high cholesterol, diabetes, asthma, heart burn)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Family History:

<u>Relative</u>	<u>Birth Year</u>	<u>Living</u>	<u>Medical Problems</u>
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