

Beacon Orthopaedics Surgery Center
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Patient _____ D.O.B. _____
 Surgery date _____
 Surgical Procedure _____

Medical History <i>Circle if Applicable</i>		Assessment				Previous Surgery YES ☐ NO ☐	
		Sys	NOR	ABN	Comments	List:	
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	<i>* K if on Diuretics</i>					
Smoker : Pack / Day		<i>* EKG needed for 50 or older or</i>				Family History:	
Alcohol intake:		<i>cardiac history</i>					
Drug Abuse:							
Menstrual History:							
Menopause:							
Hysterectomy:							
LMP		<i>Patient is medically cleared for surgery</i> YES ☐ NO ☐					
VS							
Height							
Weight		Physician's Signature/ Date					