PACIFIC
FAMILY
MEDICINE

1441 Avocado Ave., Suite 503
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Preoperative Exam

Name: _____ Date of Birth: _____ Todays Date: _____
(Please Print)
Date of Surgery: _____ Proposed Surgery: _____

Surgeon: _____

Current List of Medications/Dose (including vitamins)

_____

_____

_____

Please list your allergies to medications: _____

Have you had any problems with previous anesthesia or surgeries including abnormal bleeding? Yes/No
If yes, please describe: _____

Have you ever had a blood transfusion: Yes/No
If yes, why? _____

Have you ever had a deep venous thrombosis or pulmonary embolus? Yes/No
If yes, what were the circumstances if known? _____

Can you walk up one flight of stairs without becoming short of breath? Yes/No

Have you had any of the following recently: (Please circle) in none, circle: **NONE**

Cold or flu symptoms or fever or chills

Problems swallowing

Chest pain or irregular heartbeat

Shortness of breath, chronic cough

Abdominal pain, nausea, vomiting, diarrhea or constipation

Blood in urine or painful urination or urinary retention

Headaches or dizziness