

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

### Winter Haven Ambulatory Surgical Center

(Please fill out before you come in for your surgery/procedure)

**ALLERGIES:** (Food, Drugs, Latex)

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:** (Prescriptions and over the counter meds- including herbs.) Please give us the dosage and how many times a day you take it or please bring a list.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIST SURGERIES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please check all illness that you currently have or have previously been diagnosed with:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Parkinsons Disease          | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Stroke/ TIA                 | <input type="checkbox"/> Limited Mobility |
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Seizeures                   |   |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Diabetes                    |   |
| <input type="checkbox"/> Heart By-Pass Surgery    | <input type="checkbox"/> Thyroid Problems            |   |
| <input type="checkbox"/> Heart Valve Replacement  | <input type="checkbox"/> Hepatitis                   |   |
| <input type="checkbox"/> Pacemaker/Defibrillator  | <input type="checkbox"/> Liver Disorders             |   |
| <input type="checkbox"/> Rheumatic Fever          | <input type="checkbox"/> Alcohol ? How much? _____   |   |
| <input type="checkbox"/> Irregular Heartbeat      | <input type="checkbox"/> Kidney Problems             |   |
| <input type="checkbox"/> Valve Disease/Murmur     | <input type="checkbox"/> High Cholesterol            |   |
| <input type="checkbox"/> Smoker?                  | <input type="checkbox"/> Artificial Limbs            |   |
| A day?----- Quit date?-----                       | <input type="checkbox"/> Metal Implants? Where _____ |   |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Dentures/Partials           |   |
| <input type="checkbox"/> Emphysema/Bronchitis     | <input type="checkbox"/> Glasses/Contacts            |   |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Hearing Aids? R/L           |   |
| <input type="checkbox"/> Cancer? Type _____       | <input type="checkbox"/> Problems w/anesthesia       |   |
| <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Family prob. w/anesthesia   |   |