Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Current Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date last seen: \_\_\_\_\_\_\_\_\_\_\_

## Notify in event of emergency:

## Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to Latex □ Yes □ No

Are you allergic to Medication □ Yes □ No If yes please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

Where do you get prescriptions filled? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all medications: (Include non-prescription)**

|  |  |  |
| --- | --- | --- |
| **NAME** | **STRENGTH (MG)** | **FREQUENCY (HOW OFTEN)** |
|  |  |  |
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|  |  |  |
|  |  |  |

**□ INCOMPLETE LIST** Reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Surgeries: (please list all) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Have you ever had any anesthetic reactions: □ Yes □ No (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Could you possibly be pregnant: □ Yes □ No

**Medical: Do you currently have or are you being treated for: (Check if yes**)

**Disorder** Test(office use) **Disorder** Test(office use)

□ Diabetes Chem 12 □ Infection CBC

□ High Blood Pressure Chem 12 □ Abnormal Bleeding CBC,PT, BT

□ Heart Attack Cardio Clear □ Recent Blood Loss CBC

□ Heart Condition EKG/CMP □ Anemia CBC

□ Asthma CXR □ Cough CXR

□ Emphysema CXR □ Dizziness/Blackouts CBC

□ Sleep Apnea CXR □ Chest Pain CXR/EKG

□ Liver Disease Liver Profile □ Nausea/Vomiting Chem 12

□ Kidney Disease Chem 12 □ Diarrhea/Constipation Chem 12

□ Cancer CBC □ Pain/Difficulty Urinating UA

□ Seizures (Epilepsy) Drug Levels □ HIV/Aids CBC/viral load

□ Thyroid Problems Thyroid Profile □ Blood Clots/Phlebitis PT/INR

 Reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have your parents, brothers, sisters, or children had: (Check if yes)**

□ Heart Problems □ Diabetes

□ High Blood Pressure □ Cancer

Current Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you live: □ Alone □ Spouse □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke cigarettes: □ Yes □ No How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages: □ Yes □ No

 □ Regularly How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Occasionally

Do you use any recreational drugs: □ Yes □ No Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been dependent on narcotics or pain pills: □ Yes □ No

What is the date of injury (if any) resulting in this surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is any litigation (lawsuit) proceeding from this injury: □ Yes □ No

What surgery do you understand will be performed: □ Right □ Left \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALL THE ABOVE INFORMATION IS TRUE AND COMPLETE. I UNDERSTAND THAT IMPORTANT FACTS CANNOT BE KNOWN IF I DO NOT INFORM THE DOCTOR, AND THIS COULD CAUSE A VERY SERIOUS PROBLEM. THIS PROCEDURE, RISKS, AND ALTERNATIVES HAVE BEEN DISCUSSED WITH ME BY THE SURGEON AND ALL MY QUESTIONS HAVE BEEN ANSWERED. I UNDERSTAND THAT IF I HAVE ANY FURTHER QUESTIONS OR CONCERNS PRIOR TO SURGERY THESE WILL BE ADDRESSED IF I CALL SIERRA ORTHOPEDICS. I UNDERSTAND THAT THERE IS NO GUARANTEE OF SUCCESS OF ANY SURGERY, AND I COULD POSSIBLY BE WORSE AFTER SURGERY.

#### SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_

##### I AM THE LEGAL GUARDIAN WITH LEGAL POWER

SIGNED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME OF PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pre Operative Physical**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_ Wt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_\_\_\_\_

General Apperance: □ Normal □ Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Status: □ Normal □ Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEENT: □ Normal □ Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lungs: □ Normal □ Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart: □ Normal □ Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abdomen: □ Normal □ Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Surgery: □ Right □ Left \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local exam of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin (Scars): □ Normal □ Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Warmth/redness: □ Normal □ Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pulses: □ Absent □ 1+ □ 2+ □ 3+ □ 4+

Swelling: □ Absent □ Present: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Edema: □ Absent □ 1+ □ 2+ □ 3+ □ 4+

Sensation: □ Normal □ Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Motor Function: □ Normal □ Abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_