	Y	N		Y	N
Have you had any previous surgery? If yes, please list: _____ _____ _____ _____ _____ **Do you or your family have any birth defects or congenital diseases?** If yes, please list: _____ _____ **Any hospitalizations in the last 6 – 12 months?** If yes, please list: _____ _____ _____ **Have you had any other major illnesses?** If yes, please list: _____ _____ **Do you have a history of MDRO (multi-drug resistant organisms) or infections? (ex. MRSA, VRE)** If yes, please explain: _____ _____ _____ **Would you rate your daily level of activity as:** Light Moderate Heavy Please explain the above activities:_____ _____ _____ **If under age 18, are your immunizations up to date?**			**Have you fallen at any time in the last 12 months?** **If yes, please explain:** _____ _____ _____ _____ **Are you afraid you might fall easily? Do you often feel dizzy or light-headed when standing?** **If yes, please explain:** _____ _____ _____ **If female, are you pregnant?** **Could you be pregnant?** Date of last menstrual period: _____ **Have you taken any ASPIRIN in the last 24 hours?** Last time you took ASPIRIN? _____AM / PM **Do you take CORTISONE or STEROIDS?** **Are you allergic to adhesive tape?** **Are you allergic to rubber or rubber products?** **Are you allergic to any medicines?** If yes, please list on the medication list page **Are you currently taking any medications?** If yes, please list on the medication list page **Do you have dentures?** Bridgework? Capped teeth? Loose teeth? **What is your weight?** _____ **What is your height?** _____ **What is your age?** _____	Y Y	N N

Signature of patient/guardian	Date/Time	Signature of Anesthesia Provider	**Date/Time**
Signature of patient/guardian	Date/Time	Signature of Anesthesia Provider	**Date/Time**
Signature of patient/guardian	Date/Time	Signature of Anesthesia Provider	**Date/Time**
Signature of patient/guardian	Date/Time	Signature of Anesthesia Provider	**Date/Time**

PATIENT LABEL