VALLEY LASER AND SURGERY CENTER, INC.
36 W. Yokuts Avenue, Suite 3 Stockton, CA 95207
(209)952-1189 Fax (209)952-1174

Health Information for Anesthesia Provider and/or Surgeon

Name (first, middle initial, last)		Date of Birth
Primary Care Provider		Phone
Cardiologist		Phone
Pulmonologist		Phone
Pharmacy		Phone
Gender: Male / Female	Height:	Weight:

Please list ALL allergies and reactions. (Include latex, povidone-iodine, & food allergies.)

Please list ALL the medications you are currently taking. (Include **herbal** and **over the counter** medications.)

Name	Dosage

Please list ALL hospitalizations, surgeries, and illnesses you have had in the past.

Type	Year

Please complete any relevant medical history that may assist us.

Heart History:

____ Open Heart Surgery ____ Heart Attack / Stroke ____ Angina (chest pain)
____ Pacemaker / Defibrillator ____ Stents / Angioplasties ____ High Blood Pressure
____ Blood Thinning Medication ____ Bleeding problems (clots/DVT/PE)
Other:_____

Lung History:

____ Asthma ____ Emphysema ____ Chronic Bronchitis ____ COPD
____ Obstructive sleep apnea (heavy snoring) ____ Cough (Sputum Y / N) ____ O2 Dependent
Can you lie flat with one pillow? Yes No
Can you do housework or take a short walk without getting short of breath? Yes No
Do you smoke? Yes No If applicable: _____ packs per day for _____ years.
Other:_____

Liver History:

____ Hepatitis ____ Jaundice ____ Cirrhosis
Do you drink alcohol? Yes No If applicable: _____ drinks per day for _____ years.
Other:_____

Kidney History:

____ Renal Disease, Stage____
____ Dialysis: hemodialysis or peritoneal dialysis? When do you receive dialysis? _____
____ Arteriovenous fistula or shunt
Other:_____

Neurological History:

____ Seizures ____ Altered Mental Status
____ Numbness / Weakness ____ Headaches / Migraines
Other:_____

Gastrointestinal History:

____ GERD / Reflux ____ Peptic Ulcer Disease
Other:

Other:

____ Diabetes ____ Thyroid disorder
____ Arthritis ____ Back or Neck problems
____ Seasonal Allergies ____Cancer Type:_____

Do you take or have you ever taken medication for your prostate? Yes No Not applicable
Are you pregnant or is there a chance you could be pregnant? Yes No Not applicable
When was your last menstrual period, if applicable? _____
Have you ever had problems with anesthesia? Yes No Explain:_____
Can you walk across a room unassisted? Yes No Explain:_____
Do you have implanted electronic or metal devices? Yes No Explain:_____
Do you have a history of an infectious disease? Yes No Explain:_____

Patient Signature:_____ Date Completed:_____

(After 90 days) I have reviewed this information and there have been no changes since the date of completion.

Patient Signature:_____ Date:_____