Pre-Surgical Medical History Form

Patient Information

Full Name

Date of Birth

Gender

Contact Number

Email

Address

Health Information

Height

Weight

Blood Type

Allergies

Current Medications

Past Surgeries / Hospitalizations

Medical History

Medical Problems (Check all that apply):

- [ ] Diabetes
- [ ] Hypertension
- [ ] Heart Disease
- [ ]

Asthma

Stroke

Kidney Disease

Other

If Other, please specify:

Anesthesia History

Have you or any family member had problems with anesthesia?

If yes, please describe: