

Pre-operative Medication Record



Patient Name:

Date:

#	Name of Medicine	Dose	How often is it taken?	When was it stopped?
0	<i>Example: Aspirin</i>	<i>81mg</i>	<i>Daily</i>	<i>September 1st</i>
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

	Yes	No	Comments	LIST ALL ALLERGIES & REACTIONS:	
				DRUGS, OTHER	REACTION
Cold, cough or fever				1. _____	_____
Difficulty Breathing				2. _____	_____
COPD/Emphysema				3. _____	_____
Asthma/Bronchitis/Pneumonia				4. _____	_____
Sleep Apnea					
TB/Abnormal CXR					
Heart Problems				LIST PREVIOUS SURGERIES:	
Chest Pain				_____	
Heart Attack - Date:				_____	
Hypertension				_____	
On Beta Blockers				_____	
Heart Murmur/MVP				_____	
Irregular Heart Rhythm/Abnormal EKG					
Congestive Heart Failure				PREVIOUS ANESTHETIC HISTORY:	
Stroke - Date:				Date of last anesthetic _____	
Pacer/ICD - Date:				Any abnormal reaction? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Kidney Disease				Comments: _____	
Diabetes				Relatives with abnormal reaction to anesthetic? _____	
Liver Problems					
Hepatitis Type:					
Jaundice				Habits:	
Bleeding Problems				Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Anemia				How many (per day) _____	
PVD/Phlebitis				How many years _____	
Blood Transfusion - previous				Do you drink alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/>	
In life threatening emergency, do you object to blood transfusions?				Average alcohol per day _____	
Arthritis				Do you use street drugs? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Back/Neck Problems				Caffeine Yes <input type="checkbox"/> No <input type="checkbox"/>	
Psychiatric/Emotional Problems				DO YOU	
Epilepsy/Seizures				YES NO	
Migraine Headaches				1. Wear contact lenses <input type="checkbox"/> <input type="checkbox"/>	
Other Medical Problems				2. Wear hearing aid <input type="checkbox"/> <input type="checkbox"/>	
Communicable Diseases				3. Wear dentures, partial, plates, bridge, have capped or loose teeth <input type="checkbox"/> <input type="checkbox"/>	
Are you pregnant?			LMP	4. Have/had fractured facial bones <input type="checkbox"/> <input type="checkbox"/>	
Phone Interview Yes <input type="checkbox"/> No <input type="checkbox"/>				5. Have difficulty opening mouth <input type="checkbox"/> <input type="checkbox"/>	
RN Signature _____ Date _____ Time _____				6. Advance Directive <input type="checkbox"/> <input type="checkbox"/>	
Transportation: _____ Phone # _____				7. Flu vaccine Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____	
				8. Pneumonia vaccine Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____	
				Height _____ Weight _____ lbs / _____ kgs	
				BP _____ P _____ R _____ T _____	
				SaO ₂ _____ %	
				RN Signature _____	
				Date: _____ Time: _____	