

List any medications and dosages: _____

List any medication allergies: _____

Have you had any prior reaction to local anesthesia? Yes ___ No ___

Serious Illnesses (Please List & date:) _____

Previous Surgery (Please list):

Operation	Year	Hospital	Surgeon	Anesthesia local/general
_____	_____	_____	_____	L ___ G ___
_____	_____	_____	_____	L ___ G ___
_____	_____	_____	_____	L ___ G ___
_____	_____	_____	_____	L ___ G ___

Do you have a condition that causes excessive bleeding? Yes ___ No ___

Does your blood clot normally? Yes ___ No ___

Do you have a condition that requires prophylactic antibiotics? Yes ___ No ___

Joint Replacement ? Yes ___ No ___

Mitral Valve prolapse? Yes ___ No ___

Prosthetic heart valve? Yes ___ No ___

Are you taking Aspirin ? Yes ___ No ___ Ibuprofen? Yes ___ No ___

Do you smoke? Yes ___ No ___ If so, how many packs a day? _____

Do you drink more than two drinks per day? Yes ___ No ___ How Much? _____

Signature

Date