Clinical Admission Data Form
(Outpatient Surgery)

RETURN COMPLETED FORM DAY OF PROCEDURE

Contact Person:			
Relationship:			
In waiting room ☐ or Phone number (please stay within 30 minutes of hospital):			
ALLERGIES:			
MEDICATIONS (include name, dosage, # per day taken)			
Do you use:	**No**	**Yes**	**How Often & Last Use**
Tobacco			Ppd_____ Quit date_____
Alcohol			# drinks/day_____ How often? _____ Last drink:_____
Marijuana			Last use:
Amphetamines			Last use:
Other			Last use:

MEDICAL & SURGICAL HISTORY		
Do you have or have you ever had: (circle all that apply and fill in others):	**YES**	**NO**
Ear, Nose, or Throat problems: (glaucoma, lens implants, dentures, loose teeth, dental caps or bridges, hearing aids, glasses, contacts or artificial eye)		
Heart Problems: (chest pain,anigina, heart attack, congestive heart failure, irregular heartbeats, pacemaker)		
Vascular problems: (high blood pressure, blood clots)		
Lung problems: (asthmas, emphysema, tuberculosis, coughing, coughing blood, abnormal chest x-ray, sleep		
Gastrointestinal problems: (hepatitis, liver cirrhosis, ulcers, hiatal hernia, intestinal bleeding)		
Genitourinary problems: (OB/GYN, kidney disease/failure, prostate problems, incontinence, STD, infections)		
Is there a possibility you could be pregnany? LMP_____		
Musculoskeletal problems: (back problems, broken bones of the face/neck/back, limited range of motion, arthritis, TMJ)		
Skin problems: (rash, hives, bruising easily, open sores)		
Neurological problems: (Seizures, paralysis/numbness, stroke, weakness, migraines, confusion)		
Mental illness: (anxiety, depression, bipolar disorder)		
Endocrine problems: (diabetes, thyroid) If diabetic, contolled by ☐ diet ☐ oral agent ☐ insulin		
Anemia/Unusual bleeding problems:		
Cancer:		
Bad reaction to anesthesia? Describe:		
Family history of high fever or muscle weakness after anesthesia?		
A religious objection to blood transfusion?		

Surgeries, procedures, hospitalizations, births, or illnesses (include dates if possible):