



BUFFALO SURGERY CENTER PATIENT HISTORY

NAME: \_\_\_\_\_ DATE OF SURGERY \_\_\_\_\_

DOB \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

RACE: (circle one) 1. Asian 2. Black 3. Amer. Indian 4. Other 5. Unknown 6. White

ETHNIC: (circle one)

- 1. Cambodian
- 2. Hmong
- 3. Laotian
- 4. Vietnamese
- 5. African
- 6. Eastern European
- 7. North American
- 8. South/Central American
- 9. Western European
- 10. Asian/Pacific Islander
- 11. Other
- 12. Hispanic / Latino
- 13. Unknown

Have you ever had surgery at our facility before \_\_\_ Yes \_\_\_ No \_\_\_\_\_ Date: \_\_\_\_\_

Name of surgeon \_\_\_\_\_

Who is your medical Doctor? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Have you had any surgeries before? If yes, indicate what type and year. \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Have you had any complications or troubles with previous anesthesia?

If yes explain: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Have your blood relatives had a reaction to anesthesia?

If yes explain: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Have you had any serious illness?

If yes explain: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Do you have any known allergic reaction to drugs?

If yes explain: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Latex allergies

If yes explain: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Are you currently taking any medication or Herbal preparation

**\*\*STOP any aspirin products, blood thinners 7 DAYS prior to surgery. Please contact your primary care physician, prescribing physician or Buffalo Surgery Center Nurse at (716) 250-6520 regarding specific directions.**

**STOP ALL HERBAL PILLS A WEEK BEFORE SURGERY.**

**DOES ANYONE IN YOUR FAMILY (AND BLOOD RELATIVES) CARRY INHERITED DISEASE?  
PLEASE CHECK WHEREVER APPLICABLE AND WRITE RELATIONSHIP.**

Sickle cell anemia \_\_\_\_\_ Hemophilia \_\_\_\_\_  
Porphyria \_\_\_\_\_ Malignant Hyperthermia \_\_\_\_\_  
Bronchial asthma \_\_\_\_\_ Diabetes \_\_\_\_\_  
Any others \_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS**

Yes  No Irregular heart beat/mitral valve prolapse  
 Yes  No Rheumatic fever or rheumatic heart disease  
 Yes  No Congenital heart disease  
 Yes  No Pain in the chest upon exertion or while resting  
 Yes  No Short of breath after mild exercise  
 Yes  No High blood pressure  
 Yes  No Short of breath when you lie down  
 Yes  No Palpitations or Fluttering heart beat  
 Yes  No Recent respiratory tract infection; cold, flu, coughing, wheezing  
 Yes  No Sinus trouble, post nasal drips  
 Yes  No Bronchial asthma/emphysema  
 Yes  No Fainting spells or epileptic seizures/convulsions  
 Yes  No Diabetes  
 Yes  No Hepatitis, jaundice or other liver disease  
 Yes  No Stomach ulcers, hiatal hernia  
 Yes  No Kidney trouble (stone, infection, etc.)  
 Yes  No Lung troubles, if yes list \_\_\_\_\_  
 Yes  No Blood disorder such as anemia of any kind  
 Yes  No Do you bruise or bleed easily? Is yes describe \_\_\_\_\_  
 Yes  No Have you ever required transfusion of blood or blood products?  
If yes, why? \_\_\_\_\_  
 Yes  No Muscle cramps muscle disease or muscle weakness paralysis, etc.  
If yes, describe \_\_\_\_\_  
 Yes  No Unexplained fevers  
 Yes  No Exposed to any recent contagious disease/illness  
 Yes  No Exercise tolerance: (circle one) good fair poor  
If you have any conditions or problems not listed above, would you please describe?  
\_\_\_\_\_

Yes  No Do you smoke HOW MANY A DAY? \_\_\_\_\_

Yes  No Do you drink alcoholic beverages: (circle one) seldom often daily

Yes  No Do you have loose/missing teeth? How Many? \_\_\_\_\_

Yes  No Do you have dentures, partial plate, capped teeth and or braces?

**WOMEN ONLY**

Yes  No Are you pregnant? Date of last menstrual period \_\_\_\_\_ last pap smear \_\_\_\_\_

**TO THE BEST OF MY KNOWLEDGE, THE ANSWERS GIVEN ARE CORRECT AND I UNDERSTAND ALL INSTRUCTIONS**

\_\_\_\_\_  
Signature/Relationship

\_\_\_\_\_  
Reviewed by Nurse/Date

\_\_\_\_\_  
Signature/Relationship

\_\_\_\_\_  
Reviewed by Nurse/Date

\_\_\_\_\_  
Signature/Relationship

\_\_\_\_\_  
Reviewed by Nurse/Date