Phone: (713) 863. 7246Fax: (713) 863.9524www.LiveWithRelief.com

PAIN RELIEF
ASSOCIATES

NAME OF PATIENT: _____

DOB:	Gender:	Age:	Height:	Weight:

INSTRUCTIONS: Please complete this form and bring it to your pre-operative visit.

Please indicate if you have or have ever had a history of any of the following:

□ YES □ NO 1. Heart disease, heart failure, heart surgery, angioplasty stent, or pacemaker/defibrillators?
□ YES □ NO 2. Shortness of breath or chest pain at rest or with any activity?
□ YES □ NO 3. High blood pressure/hypertension?
□ YES □ NO 4. Do you have any loose or chipped teeth, or removable dentures?
□ YES □ NO 5. Taking beta-blocker medication?
□ YES □ NO 6. Blood clots in legs or lungs, stroke, TIA ("mini-stroke"), seizure, black out spells (loss of consciousness), or abnormal/irregular heart rhythm?
□ YES □ NO 5. Currently taking or have taken blood thinner, such as Aspirin, Coumadin, Xarelto, Pradaxa, Lovenox, Fragmin, Plavix, Elliquis, or Effient?
□ YES □ NO 6. Special heart test or procedure, such as heart catheterization, coronary angiogram, echocardiogram, stress test, or heart nuclear scan?
□ YES □ NO 7. Asthma, chronic bronchitis, emphysema, or chronic obstructive pulmonary disease (COPD)?
□ YES □ NO 8. Sleep apnea or been told you snore, choke, or gasp when sleeping?
□ YES □ NO 9. Cold, flu, bronchitis, respiratory illness, cough, fever, rash, or urinary infection within two (2) weeks?
□ YES □ NO 10. Nerve or muscle disease or injury, especially causing weakness, pain, or numbness?
□ YES □ NO 11. Diabetes?
□ YES □ NO 12. Kidney or bladder problems, including dialysis?
□ YES □ NO 13. Liver disease (hepatitis or cirrhosis)?
□ YES □ NO 14. Excessive or abnormal bleeding tendency (including family members) associated with surgical or dental procedure?
□ YES □ NO 15. Any anesthesia related problems (including family members), such as malignant hyperthermia, fever associated with anesthesia, or difficult intubation (insertion of breathing tube)?
□ YES □ NO 16. Use of steroids (cortisone/prednisone) in the past year?

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List any allergies, intolerances, medications, vitamins, dietary supplements, herbal supplements, and over-the-counter drugs you currently take or have taken in the last 6 months.

PLEASE BE AWARE THAT EATING OR DRINKING 8 HOURS PRIOR TO ANESTHESIA CAN LEAD TO CANCELLATION OF YOUR PROCEDURE! YOU MAY TAKE ANY OF YOUR MEDICATIONS IF INSTRUCTED TO DO SO BY YOUR PHYSICIAN WITH A SMALL AMOUNT OF CLEAR WATER BEFORE SURGERY.

Allergies/Contraindications/Sensitivities/Reactions: No Known Allergies ☐

Medication/Dietary Supplements/Food Others	A = Allergy C = Contraindication S = Sensitivity	Reactions	H = High M = Medium L = Low

PTA Prescriptions/OTC Medications/Dietary/Herbal Supplements: None ☐

Name	Dose	Frequency	Date of Last Dose

Medical History	Surgical History

Signature of Patient or person completing form: _____

Date: _____