AUSTIN FERTILITY SURGERY CENTER

6500 N. Mopac, Bldg. 3, Suite 3104
Austin, Texas 78731

PATIENT ADMISSION HISTORY

HEIGHT:____________________ **WEIGHT**:____________________ **DATE:**______________________ **BMI:**_________

1. **Patient Name:**___________________________________ **Form Completed By:** ________________________________
2. **Phone Number:**____
3. **In case of emergency, contact:**_____________________________**Relationship:**_____________________________
4. **Reason for visit:**____
5. **List the surgeries and/or hospitalizations that you've had:**____
____
6. **List all medications (prescribed and over the counter):**____
____
7. **Medication Allergies (please list the name of the medication and the reaction it causes):**________________________
____
8. **Do you have or have you ever been told by a doctor that you have an allergy to any latex product?** ☐ **Yes** ☐ **No**
9. **Have you ever had a reaction to the dye used for some x-ray procedures?**______________________ ☐ **Yes** ☐ **No**
10. **Have you or a relative ever had a reaction to anesthesia?**____________________________________ ☐ **Yes** ☐ **No**
11. **Do you have a history of malignant hyperthermia (condition that occurs after anesthesia)?**______ ☐ **Yes** ☐ **No**
12. **Have you ever had a reaction to muscle relaxant medications?**______________________________ ☐ **Yes** ☐ **No**

PLEASE CHECK ALL ITEMS: **DATE/TIME TRIGGER SHOT:**

YES	**NO**		**YES**	**NO**	
		Heart Problems/High Blood Pressure			Diabetes ☐ Adult Onset ☐ Juvenile Onset
		Pacemaker or ICD			Fever and/or Chills
		Circulation Problems/Raynaud's/Blood Clots			Night Sweats
		Persistent Cough >2 Weeks			Unplanned Weight Loss
		Sleep Apnea/Asthma/Bronchitis/TB			Implants/Prosthetics
		Coughing Up Blood			COVID Infection
		Bleeding/Anemia Problems			COVID vaccine
		Previous Blood Transfusion			Cancer
		Neurological Problems/Seizures			Transplant
		Musculoskeletal Problems/Fibromyalgia/Lupus			If Female, Gynecological Problems
		Gastrointestinal/Digestive Problems			Anxiety/Depression/Panic Attacks/Bipolar
		Urinary/Kidney Problems			Hepatitis
		Snoring			Neck Size for male size 17 in or greater
		Tired			Neck Size for female size 16 in or greater
		Observed: Has anyone observed you stop breathing, choking, or gasping during sleep			HIV ☐ Not Tested ☐ Tested Negative
		Ear/Nose/Throat Problems/Sleep Apnea			☐ Tested Positive ☐ Unknown
		Endocrine/Thyroid Problems			Sexually Transmitted Disease

COMMENTS: (Please comment on all YES questions):____
____
____

Name of Provider(s) treating checked concerns: ____

______________________________ ______________________________ ______________________________
Form reviewed by: RN Name (printed) RN Signature Date Date sent to Anesthesia for Review

☐ Approved By: ________________________ ☐ Denied By: ____
Anesthesiologist Name/ Date Anesthesiologist Name/Date & reason denied