AUSTIN FERTILITY
SURGERY CENTER

6500 N. Mopac
Bldg. III, Suite 3104
Austin, Texas 78731
Tel: (512) 614-4830
Fax (512) 284-7899

Patient Admission History

Date:_____ Height:_____ Weight:_____ 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 have 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 every 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: _____
Anesthesiologist Name/ Date

❒ Denied By: _____
Anesthesiologist Name/Date & reason denied.