NAME: ____ Date of Birth: _________________

How tall are you: ___________ Current weight: ____________

What Pharmacy do you use?

List all Medications you are currently taking: ☐ I do not take medicine regularly.

(please include dose and how often you take)

List any Medication allergies and the reaction you have: ☐ I have no medication allergies.

Check if you are allergic to: ☐ Contrast Dye ☐ Latex ☐ Tape

List any Surgeries you have had: ☐ I have never had surgery.

Have you ever had problems with anesthesia? ☐ Yes ☐ No

Has anyone in your immediate family had problems with anesthesia? ☐ Yes ☐ No

If yes, what: