ALEXANDER MILLER, M.D.

Preoperative Checklist

Name:_____Date:_____

Do you presently have or have you had any of the following conditions?
Please check “no” or “yes”

Heart disease ..... ☐ No ☐ Yes
If Yes, list type of disease:_____

Heart rhythm disorders (arrhythmia)..... ☐ No ☐ Yes

Prolapsed mitral valve ..... ☐ No ☐ Yes

Artificial heart valve ..... ☐ No ☐ Yes

Pacemaker ..... ☐ No ☐ Yes

Heart attack ..... ☐ No ☐ Yes

Coronary artery bypass surgery ..... ☐ No ☐ Yes

Coronary artery (heart) stent ..... ☐ No ☐ Yes

Poor blood circulation ..... ☐ No ☐ Yes

Stroke ..... ☐ No ☐ Yes

Bleeding disorders..... ☐ No ☐ Yes

Artificial joints..... ☐ No ☐ Yes

Hepatitis..... ☐ No ☐ Yes

HIV infection ..... ☐ No ☐ Yes

Seizures (epilepsy) ..... ☐ No ☐ Yes

Fainting..... ☐ No ☐ Yes

Allergies to medications..... ☐ No ☐ Yes
List:_____

Allergies to anesthetics..... ☐ No ☐ Yes
List:_____

Medications presently taking (attach list, if convenient)_____

_____

Are you pregnant? ..... ☐ No ☐ Yes (question optional for males)