IN-OFFICE PROCEDURE FORM

Last Name ______________________________ First____________________ MI______

Date of Birth _________ Age _____

1. Have you had any past surgeries? ___ NO ___ YES

2. Have you ever had problems with anesthesia? ___ NO ___ YES

   If yes, please tell us what happened ____________________________________

   ____

3. Have you taken any **blood thinning products in the last 72 hrs** such as aspirin, fish oil, Vitamin E, Excedrin, Plavix, or Coumadin?

   ___ NO ___ YES

4. When was the last time you had anything to eat? ____________________________

   What did you eat? ____

5. When was the last time did you had something to drink? _______________________

   What did you drink? ____

6. Did you take any medication(s) this morning? ___ NO ___ YES

   If yes, please list ____

7. Do you have someone to drive you home after you procedure? ___ NO ___ YES

   Name and relation to you ____

________________________________ Patient Signature

____
Date