Northwestern Medicine®
Center for Fertility and Reproductive Medicine

PATIENT PREOPERATIVE HISTORY – FRM PATIENT ONLY

Name _____ **DOB** _____ **Today's Date** _____

Primary Care Physician _____ **PCP Phone #** _____

Please list all previous surgeries (and approximate dates)

Please list any allergies to medications, latex, food or other (and your reactions to them)

List all medications (include over-the-counter drugs, inhalers, herbals, supplements, and aspirin)

Drug Name **Dose and How Often?**	**Drug Name** **Dose and How Often?**
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Weight: (lbs or kg) _____ Height: (inches or cm) _____ (Circle the measurement units you use)

Please check any of the following that apply to your health:

☐ **Heart attack at any time**	☐ **Heart stent at any time**	☐ **LVAD**
☐ ***Heart attack within past 60 days**	☐ **Atrial fibrillation**	☐ **Heart device**
☐ **Chest pain or pressure with activity**	☐ **Arrhythmia**	☐ **Pacemaker**
☐ **Angina**	☐ **Congenital heart disease**	☐ **Defibrillator**
☐ **Heart failure**	☐ Hypertension	☐ **Fainted in the last year**
☐ **Heart surgery**	☐ **Murmur**	☐ Pain in legs while walking
☐ ***Heart stent in the last 6 months**	☐ **Valve disorder**	☐ None of these

☐ **Unable to climb 2 flights of stairs or walking 2 blocks because of chest pain or trouble breathing**

☐ **Oxygen at home**	☐ **Severe cough**	☐ **Pneumonia in last 2 months**
☐ **Pulmonary hypertension**	☐ **COPD**	☐ **Any problems with your lungs**
☐ **Trouble breathing at rest or with minimal exertions**	☐ Asthma requiring daily meds / exacerbation within 30 days	☐ None of these

Name _____ **DOB** _____

☐ Face, arm or leg weakness	☐ **Dementia**	☐ **Spinal cord injury**
☐ ***Stroke/TIA within past 60 days**	☐ Parkinson's	☐ **Brain tumor**
☐ Stroke or TIA at any time	☐ **Myasthenia gravis**	☐ **Brain aneurysm or AVM**
☐ Paralysis	☐ **Muscular dystrophy**	☐ **Epilepsy, blackouts or seizures**
☐ Difficulty speaking		☐ None of these

☐ **Hospitalized in last 30 days**	☐ **Liver disease**	☐ **Lupus**
☐ Anemia requiring treatment/transfusion	☐ **Cirrhosis**	☐ **Rheumatoid arthritis**
☐ **Sickle cell disease**	☐ Hepatitis B/C	☐ **Scleroderma**
☐ **Blood transfusion in last 3 months**	☐ **Jaundice**	☐ Sjogren's
☐ **Blood clots in leg or lung / Pulmonary embolus**	☐ **Hyperthyroidism**	☐ Jehovah's Witness
☐ Diabetes	☐ Hypothyroidism	☐ **Use illegal drugs (excluding marijuana)**
☐ **Cancer: What type? _____**	☐ **Adrenal disorder**	☐ **Kidney failure**
☐ **Chemo or radiation last 3 months**	☐ **Pituitary disorder**	☐ Taking antibiotics for any reason
☐ **Kidney disease other than stones**	☐ **Dialysis**	☐ None of these

☐ **Blood thinners or anticoagulants other than aspirin**	☐ **Hemophilia**	☐ Severe nose bleeds
☐ **Bleeding with surgery or tooth extractions**	☐ **Von Willebrands**	☐ None of these
	☐ **Known bleeding disorder**	

☐ Malignant hyperthermia (in blood relatives or self) with anesthesia	☐ Dentures
☐ Severe nausea or vomiting from anesthesia	☐ Problems opening your mouth
☐ **Difficult airway with anesthesia**	☐ Loose teeth
	☐ None of the these

☐ **Unintentional weight loss > 10 lbs**	☐ Feel that everything you did was an effort: ____ days in the last week
☐ Difficulty getting out of bed/chair by yourself	
☐ Difficulty making your own meals	☐ **Need assistance with eating or bathing or dressing**
☐ Your physical abilities limit your daily activities	☐ Fallen in the last 6 months (___ times)
☐ Difficulty doing your own shopping	☐ None of these

☐ Tired/fall asleep frequently during the day	☐ Very loud snoring	☐ Sleep apnea; Uses CPAP
☐ **Observed to stop breathing during sleep**	☐ **Sleep apnea; NO CPAP**	☐ None of these
☐ High blood pressure/Hypertension		

☐ Cannot speak and/or understand English	☐ Deaf	☐ None of these
☐ **Cannot lie flat for 45 min**	☐ Blind	

☐ Currently pregnant. Last menstrual period began:_____

☐ Smoker (current or past) _____ packs/day for _____years. Quit date_____

☐ Drink alcohol. How much each day? _____beers _____ glasses of wine _____shots of hard alcohol

Please list any medical illness or medications not noted already: