

Patient Past Surgical History Record

This record is maintained for the patient's clinical file and pre-operative assessment. Please complete all fields as accurately as possible.

Patient Demographics

Patient Full Name: Date of Birth:
Medical Record Number (MRN): Current Date:

Surgical History Table

List all prior surgeries, major medical procedures, or hospitalizations.

Surgery / Procedure	Approximate Date / Year	Hospital / Facility	Surgeon Name	Indication / Complications
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Anesthesia and Implant History

Have you ever had an adverse reaction to anesthesia? (If yes, describe):

Do you have a family history of anesthesia complications (e.g., Malignant Hyperthermia)?:

Do you currently have any internal implants or medical devices? (e.g., pacemaker, artificial joints):

Verification and Signatures

I certify that the above history is accurate to the best of my knowledge.

Person Completing Form: Relationship to Patient:
Signature: Date Signed: