

Date Submitted:	Date Printed:
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Patient Demographics	Patient Name:		Preferred Name:		
	Day Phone:		Cell Phone:		
	Evening Phone:				
	Height:	Weight:	BMI:	Sex: M F	Date of Birth:
	Your Name:		Phone Number:		
	Relationship to Patient:				
	*If you are a legal guardian, have power of attorney, or advanced directives (living will), please bring documentation.				
	Procedure Date:		Procedure Time:		
	Name of Surgeon:				
	Description of Procedure:				
	Emergency Contact Name:		Phone Number:		
	Name of person driving patient home from surgery:				
Name of person who will care for patient after surgery:					

Lab work	Has the patient had any of the following in preparation for surgery? If yes, please include date/location.				
	Have you had an EKG done in preparation?	YES	NO	where:	when:
	Have you had any x-rays in preparation?	YES	NO	where:	when:
	Have you had any blood tests in preparation?	YES	NO	where:	when:
	Have you had anything else done in preparation?	YES	NO	where:	when:
If yes explain:					

Question	YES	NO	Comments/Explanation
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Allergies	Drug allergies? (please list)			Drug/Allergy:
	Do you have any food allergies? (please list)			
	Latex/rubber allergies?			
	Other known allergies? (please list)			
	Other abnormal drug reactions? (explain)			

Diabetes	Are you diabetic ?			
	Is your diabetes diet controlled ?			
	Do you use:	Injectable Insulin		
	(Circle One)	Oral Medications		
	Insulin Pump			
	Do you have hypoglycemia?			

Anesthesia	Have you or anyone in your family had an unusual reaction to anesthesia such as high temp, difficulty waking up, nausea and/or vomiting?			
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Surgical History	Procedure:	Date:	
	Procedure:	Date:	
	Procedure:	Date:	
	Procedure:	Date:	
	Procedure:	Date:	
	Procedure:	Date:	
	Were you able to list ALL of your surgeries above?	YES	NO
	Do you have any implants or prostheses ?	YES	NO
	Type:	Location:	Date:
Type:	Location:	Date:	

<b>Medications</b>	Is the patient currently taking any medications ? (herbal, prescribed, over-the-counter, steroids, diet pills, other)		YES	NO	If yes, please include name/dosage/how often
	1	Dosage:	How often:		
	2	Dosage:	How often:		
	3	Dosage:	How often:		
	4	Dosage:	How often:		
	5	Dosage:	How often:		
	6	Dosage:	How often:		
	7	Dosage:	How often:		
	8	Dosage:	How often:		
	Did your doctor instruct you stop taking any medications in preparation for surgery?		YES	NO	If yes, please include name/dosage/last taken
	1	Dosage:	Last taken:		
	2	Dosage:	Last taken:		
	3	Dosage:	Last taken:		
	4	Dosage:	Last taken:		
	Did your doctor instruct you take any medications before you come to the center for surgery ?		YES	NO	If yes, please include name/dosage/time taken
	1	Dosage:	Time taken:		
2	Dosage:	Time taken:			
3	Dosage:	Time taken:			
4	Dosage:	Time taken:			
Were you able to list ALL of your medications above?		YES	NO	Please include name/dosages on back	
<b>Doctors</b>	Please list physicians who care for you on a regular basis and/or during the past year (include primary care)				
	Physician:	Specialty:	Phone:		
	Physician:	Specialty:	Phone:		
	Physician:	Specialty:	Phone:		
	Physician:	Specialty:	Phone:		
	Physician:	Specialty:	Phone:		
<b>Question</b>		<b>YES</b>	<b>NO</b>	<b>Comments/Explanation</b>	
<b>Impairments/Disabilities</b>	Do you have any hearing impairments?				
	Vision impairments? Including glasses/contacts?				
	Mobility impairments?				
	Artificial limbs ?				
	Will you need help reading the written information given to you at our center?				
	Other impairments/disabilities? (explain)				
<b>Dental</b>	Do you have any dentures/bridges?				
	Caps or crowns?				
	Chipped or loose teeth ?				
	Do you wear any retainers ?				
<b>Skin</b>	Do you have any burns ?				
	Rashes ?				
	Bruises?				
	Other skin conditions ? (explain)				
	Does your skin tear easily ?				

Question		YES	NO	Comments/Explanation
Stomach	Do you have ulcers or hiatal hernia?			
	Acid reflux disease?			
	Gallbladder conditions?			
	GI/rectal bleeding?			
Psychiatric	Have you ever been treated for depression?			
	Anxiety or panic disorder ?			
	Substance abuse ?			
	Developmental delays ?			
	Other psychiatric conditions?			
Neurological	Have you ever had a stroke or TIA? (give dates)			date(s)
	Have you ever had any seizures ?			
	Do you suffer from any paralysis ? (explain)			
	Do you have Alzheimer's ?			
	Parkinson's ?			
	Other neurological conditions ? (explain)			
Musculoskeletal	Do you have any neck, back, or jaw problems?			
	Joint replacement or dislocation ?			
	Muscular dystrophy ?			
	Arthritis ?			
	Other musculoskeletal conditions ? (explain)			
Hematological & blood disorders	Have you ever had a blood transfusion ?			date(s)
	Blood Clots ?			
	Do you have sickle cell disease ?			
	Anemia ?			
	Other blood conditions? (explain)			
	Do you bruise easily			
	Are you taking any blood thinners?			
	Are you taking aspirin or ibuprofen?			
	Are you taking Vitamin E?			
Does your family have a history of hemophilia ?				
Liver	Do you have jaundice			
	Cirrhosis?			
	Hepatitis? (list type)			
Thyroid	Do you have hypothyroidism?			
	Hyperthyroidism ?			
	Other thyroid conditions?			
Kidney	Burning when urinating?			frequency:
	Bleeding when urinating ?			frequency:
	Are you on dialysis?			
	Do you have any other urinary problems?			

Question		YES	NO	Comments/Explanation
0-No Pain (1-2)Hurts a little Bit (3-4)Hurts a little more (5-6)Hurts even more (7-8)Hurts a whole lot (9-10)Hurts the worst				
Pain	Do you have chronic pain?			location: pain scale: (0-10) how long:
	Do you currently have pain associated with the condition for which you are having this procedure?			location: pain scale: (0-10)
Cardiovascular	Do you have or have you ever had angina/chest pain ?			
	High blood pressure ?			
	Low blood pressure?			
	Rheumatic fever ?			
	Congestive heart failure?			
	Mitral valve prolapse ?			
	Heart surgery/stent/catheter ?			date(s):
	Heart Attack ?			date(s):
	Palpitations or an irreg. heart beat ?			
Do you use a pacemaker/defibrillator ?			date(s): type/date(s):	
Pulmonary	Do you have asthma?			
	Restrictive airway disease (RAD) / Bronchitis / COPD ?			
	Sleep Apnea ?			
	Do you have or have you ever been exposed to TB ?			
	Do you use a Nebulizer , Home Breathing Machine or Oxygen at home?			
	Do you ever have shortness of breath?			
	Do you smoke/use tobacco ? (if yes, how much?)			packs per day:
	Have you had a cold in the past 2 weeks ?			
	Have you traveled to a foreign country ? If yes, when and where ?			When/ Where:
Other	Do you drink alcohol?			
	Do you use recreational drugs ?			
	Do you have any body piercings?			
	Do you have any contagious diseases ?			
	Do you have or have you ever had cancer ?			
	Are you currently participating / enrolled in a medical research study ?			
	Have you been hospitalized in the last six months ?			Reason/Date:
	Patient's primary language: English Spanish Other:			
	Will the patient need an interpreter ?	YES	NO	
	Will the patient bring an interpreter ?	YES	NO	Name:
	Has the patient been to this center before?	YES	NO	Date:
Are there any spiritual/cultural needs ?	YES	NO	Explain:	

Question		YES	NO	Comments/Explanation
Women	When was your last menstrual period: _____ date:			
	Are you pregnant or trying to get pregnant?	YES	NO	
Minors	Was the patient born pre-mature?			
	Are the patients's immunizations up to date ?			
	Does anyone in your home smoke or use tobacco ?			
Special Needs/Concerns?				
Comments:				

Additional Medications and Supplements			
1		Dosage:	How often:
2		Dosage:	How often:
3		Dosage:	How often:
4		Dosage:	How often:
5		Dosage:	How often:
6		Dosage:	How often:
7		Dosage:	How often:
8		Dosage:	How often:

Additional Stopped Medications			
1		Dosage:	Last taken:
2		Dosage:	Last taken:
3		Dosage:	Last taken:
4		Dosage:	Last taken:
5		Dosage:	Last taken:

Additional Presurgery Medications			
1		Dosage:	Time taken:
2		Dosage:	Time taken:
3		Dosage:	Time taken:
4		Dosage:	Time taken:
5		Dosage:	Time taken:

Additional Physician Information			
Physician:		Specialty:	Phone:
Physician:		Specialty:	Phone:
Physician:		Specialty:	Phone:
Physician:		Specialty:	Phone:
Physician:		Specialty:	Phone:

Additional Surgical Procedures		
Procedure:		Date:
Procedure:		Date:
Procedure:		Date:
Procedure:		Date:
Procedure:		Date:

Additional Implants/Prosthesis		
Type:	Location:	Date:
Type:	Location:	Date:

RN/Reviewer's Signature:	Date:
Patient/Caregiver Signature:	Date:
Other Signature:	Date: