Date Submitted:	Date Printed:

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:				

Labwork

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
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: **(Circle One)** **Injectable Insulin** **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?			

Patient Name: Date Printed:

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	Please include procedure/date on back.
Do you have any **implants or prostheses** ?	YES	NO	
Type: Location:			Date:
Type: Location:			Date:

Medications

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

Doctors

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:

Impairments/ Disabilities

Question	YES	NO	Comments/Explanation
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)			

Patient Name: Date Printed:

	Question	YES	NO	Comments/Explanation
Dental	Do you have any **dentures/bridges**?			
	Caps or crowns?			
	Chipped or loose teeth ?			
	Do you wear any **retainers** ?			
Skin	Do you have any **burns** ?			
	Rashes ?			
	Bruises?			
	Other skin conditions ? (explain)			
	Does your **skin tear easily** ?			
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 ?			

Patient Name: Date Printed:

	Question	YES	NO	Comments/Explanation
Kidney	**Burning when urinating**?			frequency:
	Bleeding when urinating ?			frequency:
	Are you on **dialysis**?			
	Do you have any other **urinary problems**?			
Pain	**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**			
	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:

Patient Name: Date Printed:

	Question	YES	NO	Comments/Explanation
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:
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:**