THE CENTER FOR SAME DAY SURGERY
PREOPERATIVE PATIENT HISTORY CHECKLIST

PATIENT LABEL

Todays Date ___________________ Patient Name ____

DOB _______/_______/_______ Age ________ HT___________ WT __________ Sex __________

Name/Number of your Primary Care Physician ____

Do You Have Any Allergies to Medications? ________ If so, List the Allergy and The Reaction. Or List Attached ☐

1. ________________________ 2. ________________________ 3. ________________________

4. ________________________ 5. ________________________ 6. ________________________

CHECK THE FOLLOWING THAT APPLY:

SYSTEMIC

___Recent Fever
___Diabetes
___Thyroid/Thyroid Surgery
___Liver Problems
___Hepatitis/Type____________
___AIDS/HIV
___Arthritis
___Seizures/Epilepsy
Last Seizure _______________
___Tremors
___Alcohol Use/ Frequency _____________
___Street Drug Use
___Cancer/ Type _______________
___History of MRSA

RESPIRATORY

___Cough, Cold, Nasal Drainage
___Asthma
___Emphysema
___COPD
___Chronic Cough
___History of Tuberculosis
___Sleep Apnea/BiPAP/CPAP
___Home O2 use _______Liters
___Smoker _______ Years _______PPD
___Exposure to 2nd Hand Smoke
___Recent Travel (past month) outside the US

VASCULAR

___High Blood Pressure
___Coronary Artery Disease
___Heart Attack _________ (Year)
___Stent(s) _________ (Year)
___Murmur/Heart Valve Condition
___Heart Failure
___Pacemaker/Defibrillator
___Irregular Heartbeat
___Heart Surgery _________ (Year)
___Recent Chest Pain
___Stroke/Paralysis
___Peripheral Vascular Disease
___Most Recent EKG _________ (Year)

GI/GU

___Stomach Problems
___Hiatal Hernia
___GERD/Reflux
___Kidney Problems
___Bladder/Prostate
___Constipation
___Diarrhea
___Current/History of C-DIFF
___Rectal Bleed/Hemorrhoids

EENT

___Cataracts
___Glaucoma
___Hard of Hearing
___Recent Ear Infection
___Sinus Problems
___Seasonal Allergies
___Tonsillitis
___Dentures/Partials/Missing or Loose Teeth

FEMALES

___Hysterectomy/Tubal Ligation
Do You Have Menstrual Cycles
_____Yes _____No
Date of Last Menstrual Cycle
____
Recent Pregnancy (Within Past Year)
_____Yes _____No
Breastfeeding (if Applicable)
_____Yes _____No

Psychosocial History ____

Any Medical Conditions Not Listed ____

Have You Ever had Anesthesia _____ Have You or any Family Member had Complications with Anesthesia? YES/NO SELF/FAMILY

List any Past Surgeries or Procedures ____

____

List Current Medications, Dose, and Frequency (Include Vitamins, Herbs, and OTC Medications) or List Attached ☐

________________________ / ________________________ / ________________________

________________________ / ________________________ / ________________________

________________________ / ________________________ / ________________________

Medications Taken Today (Day of Procedure) ____

☐ If This Form Was Filled Out Prior to this Date, I Attest That There are No Changes

Patient/Guardian Signature ____ Date ___________________

*********************PATIENTS DO NOT WRITE BELOW THIS LINE*********************

Nurse's Notes ____

____

Reviewed by RN: ____ DATE: ___________________

I have discussed the anesthesia management, risk, and complications with the patient and have answered questions to the patient's satisfaction.
I have reviewed the patient's preoperative medical status and I believe this patient will tolerate the proposed procedure.

____M.D. Anesthesiologist ___________________(DATE)