THE CENTER FOR SAME DAY SURGERY
PATIENT HISTORY CHECKLIST

*****PLEASE BRING A VALID PHOTO ID & INSURANCE CARD TO SURGERY CENTER*****

Todays Date ______________ Patient Name ____

DOB _____/_____/_____ Age ______ HT________ WT ________ Sex ________

Name/Number of your Primary Care Physician ____

Do you have a Latex allergy? **YES/NO** Do You Have Any Allergies to Medications? **YES/NO** If so, List the Allergy and The Reaction:

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 **YES/NO** 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 date of Surgery, 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 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)