

Ambulatory Surgical Record

Patient Name: _____

Phone # _____

Preoperative History

Date of Birth _____		Age: _____		<input type="checkbox"/> M	<input type="checkbox"/> F	Ht: _____	Wt: _____	BMI: _____	
Y	N	SPECIAL CONSIDERATIONS							
		COMMUNICATION PROBLEMS HEARING/VISION				HAVE YOU DISCUSSED WITH YOUR SURGEON; THE NECESSITY AND APPROPRIATENESS OF THE PROPOSED SURGERY AS WELL AS ALTERNATIVE TREATMENTS. <input type="checkbox"/> YES <input type="checkbox"/> NO DO YOU HAVE ANY QUESTIONS OR CONCERNS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
		PHYSICAL LIMITATIONS? (Walker, WC)							
LATEX ALLERGIES:		<input type="checkbox"/> NONE							
MEDICATION ALLERGIES:		<input type="checkbox"/> NONE							
FOOD/OTHER ALLERGIES:		<input type="checkbox"/> NONE							
IV DYE Allergies:		<input type="checkbox"/> NONE							
PREVIOUS HOSPITALIZATION OR OPERATIONS (INDICATE APPROXIMATE YEAR)									

****HAVE YOU HAD A BAD REACTION TO ANESTHESIA** YES NO

****HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA** YES NO

DO YOU HAVE or HAVE YOU HAD	Y	N	DO YOU HAVE or HAVE YOU HAD	Y	N
DIABETES (Controlled by: Diet, Pills, or Insulin)			THYROID PROBLEMS		
HYPOGLYCEMIA (Low Blood Sugar)			DIFFICULTY OPENING MOUTH (TMJ)		
HEART PROBLEMS (Rheumatic fever, Murmur, Heart Attack, chest pain, Irregular Heart Beat, EKG Changes, Angina, Ankle Swelling, Valve Replacement)			BACK, NECK, OR BROKEN BONES IN SPINE (Strain, Disc Problems, Numbness, or Tingling)		
			ARTHRITIS		
			SEVERE HEADACHES		
Have your had any recent bouts of chest pain or SOB?			MUSCLE DISORDERS (MD, Myasthenia Gravis)		
HIGH BLOOD PRESSURE			SKIN DISORDERS (Eczema, Psoriasis)		
LUNG PROBLEMS (Asthma, Chronic Cough, Pneumonia, Wheezing, SOB, Emphysema, Abnormal Chest X-Ray)			CANCER		
			MENTAL HEALTH ISSUES / PHOBIAS: Anx/Dep		
			OTHER MEDICAL PROBLEMS/CONDITIONS		
SLEEP APNEA (Breathing Interruption During Sleep or on Oxygen)			DO YOU HAVE A HISTORY OF SMOKING? PPD? _____ DATE QUIT? _____		
BLOOD CLOTS, TRANSFUSION PROBLEMS			Are You Around Second Hand Smoke?		
BLEEDING TENDENCIES (Hemophilia)			Do You Drink Alcoholic Beverages? HOW OFTEN? _____ HOW MUCH? _____		
STROKE (Weakness or Numbness on one side, Difficulty Speaking, Loss of Vision)			DO YOU HAVE A HISTORY OF OR ARE YOU TAKING ANY RECREATIONAL DRUGS?		
SEIZURES (Epilepsy, Convulsions)			NORTHPOINTE SURGICAL CENTER		
STOMACH PROBLEMS (Ulcer, Hiatal Hernia, Reflux, Heartburn)					
BOWEL PROBLEMS (IBS, Constipation)					
LIVER PROBLEMS (Jaundice, Hepatitis)					
KIDNEY, BLADDER, OR PROSTATE PROBLEMS					

Preoperative History - CONTINUED

ANY IMPLANTS, PROTHESIS, OR METALS:			PROCEDURE: _____ Dt: _____ PATIENT HISTORY REVIEWED WITH: <input type="checkbox"/> PT OTHER: _____ RN SIGNATURE: _____ Dt: _____
DO YOU HAVE ANY OF THE FOLLOWING: <i>(Please circle the following)</i> BRACES/RETAINERS FALSE TEETH BRIDGES BODY PIERCINGS LOOSE TEETH CAPPED TEETH CHIPPED TEETH CONTACT LENSES			Any illness, Cold, Cough, or fever in the last wk?
			Any recent exposure to communicable diseases?
			Brief Description of History Changes: N/A
RELIGIOUS/CULTURAL PREFERENCE: _____			
DO YOU HAVE AN ADVANCED DIRECTIVE OR LIVING WILL (If yes; Please Bring a Copy)			Anesthesia Clearance Needed N/A
			Cleared by: _____ Labs EKG
HAVE YOU MADE ARRANGEMENTS FOR ASSISTANCE AFTER YOUR SURGERY?			PROCEDURE: _____ Dt: _____ PATIENT HISTORY REVIEWED WITH: <input type="checkbox"/> PT OTHER: _____ RN SIGNATURE: _____ Dt: _____
DO YOU NEED A RELEASE FOR WORK OR SCHOOL?			Any illness, Cold, Cough, or fever in the last wk?
			Any recent exposure to communicable diseases?
MEDICATIONS/OTC: (IF YES SEE LIST)			Brief Description of History Changes: N/A
IF THE PATIENT IS A CHILD			
WAS THE CHILD PREMATURE?			
ANY BIRTH DEFECTS OR DEVELOPMENTAL PROBLEMS?			Anesthesia Clearance Needed N/A
			Cleared by: _____ Labs EKG
ANY IMMUNIZATION PROBLEMS OR DELAYS?			PROCEDURE: _____ Dt: _____ PATIENT HISTORY REVIEWED WITH: <input type="checkbox"/> PT OTHER: _____ RN SIGNATURE: _____ Dt: _____
ANY HISTORY OF HOLDING BREATH, CROUP, OR BREATHING PROBLEMS?			Any illness, Cold, Cough, or fever in the last wk?
			Any recent exposure to communicable diseases?
DAY BEFORE SURGERY INSTRUCTIONS			Brief Description of History Changes: N/A
Diet Instructions and Medication			
Clothing and Bathing Instructions			
Remove Contacts, Jewelry, Dentures			
You must have a person to drive you			
If menses female, urine sample req			Anesthesia Clearance Needed N/A
Labs, EKG on chart (if applicable)			Cleared by: _____ Labs EKG
Patient received the following:			PROCEDURE: _____ Dt: _____ PATIENT HISTORY REVIEWED WITH: <input type="checkbox"/> PT OTHER: _____ RN SIGNATURE: _____ Dt: _____
Pic ID, Proof of Insurance and pmt portion (if applicable)			
Advanced Directives; If no refer to website			
Patient received the following:			Any illness, Cold, Cough, or fever in the last wk?
Brochure/Ownership Disclosure/Pt Rights			Any recent exposure to communicable diseases?
Business Office			Brief Description of History Changes: N/A
PROCEDURE: _____ Dt: _____ PATIENT HISTORY REVIEWED WITH: <input type="checkbox"/> PT OTHER: _____ RN SIGNATURE: _____ Dt: _____ Arrival Time: _____ LMP: _____ N/A YES NO			Anesthesia Clearance Needed N/A
Any illness, Cold, Cough, or fever in the last wk?			Cleared by: _____ Labs EKG
Any recent exposure to communicable diseases?			
Brief Description of History Changes: N/A			
Anesthesia Clearance Needed N/A			
Cleared by: _____ Labs EKG			

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