Date of Surgery:	Patient Name:	Age:	Sex: M/F	Birth Date:	Weight:	Height:
Phone Number:	Cell Number:	Work Number: May we call here?				
Procedure:	Surgeon:	Primary Care Dr. & Phone Number:				

GENERAL QUESTIONS:		GI:	
1. Have you had problems with Anesthesia in past?	Yes / No	30. Stomach ulcer, hiatal hernia, GERDS, severe heartburn?	Yes / No
2. Family Problems with Anesthesia?	Yes / No	EYE/EARS:	
3. Do you Smoke? PPD?	Yes / No	31. Glaucoma?	Yes / No
Alcohol Use? Drug Use?	Yes / No		
4. Sleep Apnea? CPAP?	Yes / No	32. Contact Lens or Glasses?	Yes / No
		33. Hearing Aids? Or HOH?	Yes / No
		Please list all medications on the attached sheet provided.	
CARDIAC:		SURGERIES: Please List Past Surgeries:	
5. High Blood Pressure?	Yes / No		
6. Heart Attack? When?	Yes / No		
Chest Pain?	Yes / No		
7. Angina? Congestive Heart Failure?	Yes / No		
8. Murmur/Valvular Problem? (MVP)?	Yes / No	ALLERGIES TO DRUGS, FOODS, LATEX: Yes/No	
9. History of Abnormal Heart Rhythm or EKG?	Yes / No		
10. When and where was your last EKG?	Yes / No		
11. Pacemaker, defibrillator?	Yes / No		
PULMONARY:			
12. History of Emphysema, Bronchitis (Chronic), Pneumonia, Asthma? Oxygen use?	Yes / No	INFECTION CONTROL	
13. Exposure to TB? (tuberculosis)	Yes / No	Do you have **now** or have you **ever** had? MRSA Hepatitis HIV VRE Herpes	Yes/No
14. Shortness of Breath? At rest? Can you climb two flights of stairs?	Yes / No		
NEURO/PSYCHOSOCIAL:		Do you presently have any blisters, rashes, unexplained redness on your body?	Yes/No
15. Seizure or Epilepsy?	Yes / No		
16. Stroke, muscle weakness, paralysis?	Yes / No	Do you presently have any open or draining skin wounds?	Yes/No
17. Back, neck or Spinal Cord Problems?	Yes / No		
18. Psychiatric Diagnosis?	Yes / No		
19. Difficulty with Walking? Wheelchair/Cane?	Yes / No	FAMILY MEDICAL HISTORY: Relationship to Patient & Age:	
20. Special Positioning Needs?	Yes / No	Heart Disease / Stroke	
21. Arthritis Problems?	Yes / No	Kidney Disease / High Blood Pressure	
22. Language/Communication Needs?	Yes / No	Diabetes / Other:	
		NURSING SECTION ONLY:	
HEMOTOLOGY/ENDOCRINOLOGY:		Anesthesia Type: General / Local	Yes / No
		Rx for Valium Given: IV Sedation:	Yes / No
23. Diabetes? (Tx: insulin-oral-diet)?	Yes / No	Antibiotics Given:	Yes / No
24. Thyroid Disease or Goiter?	Yes / No		
25. Liver (Cirrhosis, Hepatitis, Jaundice, Kidney	Yes / No	Enema Given: (Pt. to do 30min. prior to arrival)	Yes / No
Disease (Dialysis)?	Yes / No		
26. Sickle Cell Disease/Trait?	Yes / No	TOS: BE HERE:	
27. Pregnancy Possible/LMP?	Yes / No		
28. Bleeding or Clotting Problems?	Yes / No	Interview date:	
29. Cancer or Leukemia/Lymphoma?	Yes / No		

LIST ALL TESTS TO BE PERFORMED PRIOR TO ASC VISIT: (IVP, CT, X-ray etc.)

MD SIGNATURE:	**Things to Remember to tell patient: Clear Liquid until 4-6 hours prior, NPO 4-6 hours prior, No ASA, NSAIDS 7d or blood thinners 4d prior, Driver, leave valuables at home**
	NURSE SIGNATURE:

Gainesville Urology ASC
Ambulatory Surgery Center

Patient Medication List

Patient Name________________________________ Date of Birth________________

Date of Surgery________________________

Source of Medication List:
❑ List/Bottles ❑ MD Office__________
❑ PT/Family Recall ❑ Other:__________

Allergies/Sensitivities (list all allergies, including food, latex and medication – please include reactions to items you list as allergies, i.e. rash, fever, nausea/vomiting, etc.)

____

____

____

Please complete this form, list **all** medications you currently take, including vitamins, herbal supplements, antacids, or other OTC (over the counter) medicines. Include Oxygen therapy and respiratory treatment meds.

TODAY'S DATE	NAME OF MEDICATION/VITAMINS/ HERBAL SUPPLEMENT/ETC.	DOSE	FREQUENCY TAKEN (once a day, twice a day, as needed, etc.	PRESCRIBING PHYSICIAN

PATIENT NOT TO FILL OUT BELOW THIS LINE

PHYSICIAN/GUASC NOT RESPONSIBLE FOR THE ACCURACY OF PATIENT REPORTED INFORMATION

❑ PATIENT IS NOT ON ANY MEDICATIONS

DATE ________________________

REASON UNABLE TO ATTAIN ________________________

SIGNATURE ________________________

❑ *New/Changed Medications for Home (Nurse to Complete)* Dose Route Frequency/Indication	Medication Info Provided
	❑
	❑
	❑
	❑
	❑

Discharging Nurse Signature

Date__________ Time__________

Patient/Guardian Signature

*This is an updated medication list.
Please take this to your next physician visit.

PATIENT LABEL HERE