Gainesville Urology ASC
Ambulatory Surgery Center

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:	
1. Have you had problems with Anesthesia in past?	Yes / No
2. Family Problems with Anesthesia?	Yes / No
3. Do you Smoke? PPD?	
Have you ever smoked?___ When did you quit?___	Yes / No
Alcohol Use? Drug Use?	Yes / No
4. Sleep Apnea? CPAP?	Yes / No
5. Do you have an Advance Directive	Yes / No
6. Policy explained to patient	Yes / No
7. Information requested on Advance Directives	Yes / No
CARDIAC:	
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
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
13. Exposure to TB? (tuberculosis)	Yes / No
14. Shortness of Breath? At rest or exertion?	Yes / No
NEURO/PSYCHOSOCIAL:	
15. Seizure or Epilepsy?	Yes / No
16. Stroke, muscle weakness, paralysis?	Yes / No
17. Back, neck or Spinal Cord Problems?	Yes / No
18. Psychiatric Diagnosis?	Yes / No
19. Difficulty with Walking? Wheelchair/Cane?	Yes / No
20. Special Positioning Needs?	Yes / No
21. Arthritis Problems?	Yes / No
22. Language/Communication Needs?	Yes / No
HEMOTOLOGY/ENDOCRINOLOGY:	
23. Diabetes? (Tx: insulin-oral-diet)?	Yes / No
24. Thyroid Disease or Goiter?	Yes / No
25. Liver (Cirrhosis, Hepatitis, Jaundice)	Yes / No
26. Kidney Disease (Dialysis)?	Yes / No
27. Sickle Cell Disease/Trait?	Yes / No
28. Pregnancy Possible/LMP?	Yes / No
29. Bleeding or Clotting Problems? Coumadin, Asprin Plavix	Yes / No
30. Cancer or Leukemia/Lymphoma?	Yes / No

GI:	
31. Stomach ulcer, hiatal hernia, GERDS, severe heartburn?	Yes / No
EYE/EARS:	
32. Glaucoma?	Yes / No
33. Contact Lens or Glasses?	Yes / No
34. Hearing Aids? Or HOH?	Yes / No
Please list all medications on the attached sheet provided.	
SURGERIES: Please List Past Surgeries:	
ALLERGIES TO DRUGS, FOODS, LATEX: Yes/No **Reaction :**	
Updated_____ by_____	
INFECTION CONTROL	
Do you have **now** or have you **ever** had? MRSA Hepatitis HIV VRE Herpes	Yes/No
Do you presently have any blisters, rashes, unexplained redness on your body?	Yes/No
Do you presently have any open or draining skin wounds?	Yes/No
FAMILY MEDICAL HISTORY: Relationship to Patient & Age:	
Heart Disease Stroke	
Kidney Disease High Blood Pressure	
Diabetes Other:	
NURSING SECTION ONLY:	
Anesthesia Type:General / Local / IV Sedation:	Yes / No
Antibiotics Given:	Yes / No
Enema Given: (Pt. to do 30min. prior to arrival)	Yes / No
TOS: **BE HERE:**	
Interview date:	

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 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