TRI-STATE SURGERY CENTER

_____ **Height:** _____ **Weight**: ____lbs _____ kg **Medical Dr**._____

Patient name **Scheduled Procedure**:_____

_____ **Reason for procedure:**_____

Date of surgery

Dear Patient,

The Surgery Center staff welcomes the opportunity to participate in your medical care. It is important that this form be completed **in ink** and returned to the surgery center in the attached envelope ***promptly***. If your surgery is scheduled in less than a week you can either drop the information by the center or fax this completed form (front and back) to 563-584-4538. **FAILURE TO COMPLETE AND RETURN THE FORM MAY RESULT IN YOUR SURGERY BEING RESCHEDULED.** Our hours of operation are 6:00 AM – 5:00 PM, Monday – Friday. WE REQUIRE YOU TO HAVE A DRIVER AT LEAST 18 YEARS OF AGE. We thank you for your cooperation & look forward to providing care for you. Please call 563-584-4514 with questions.

Please explain any "Yes" answers in the space provided

	YES	*NO*
Have you or anyone in your family ever had a problem with anesthesia, including nausea and vomiting?		
Do you wear contact lenses?		
Do you have any loose, chipped, capped or crowned teeth?		
Do you wear any dentures, bridges, braces or other dental appliances?		
Last menstrual period		
Are you or could you be pregnant?		
Do you currently smoke? Packs per day_____ Years____		
Have you smoked in the past? Quit _____ years ago		
Do you drink alcoholic beverages? If yes, how much?		
Have you ever used recreational (street) drugs? If yes list drugs and last date used.		
Amt of caffeine/day (coffee, tea or soda) _____		
Are you able to walk up one flight of stairs without difficulty?		
Do you exercise?		
Do you work?		
Have you had an EKG or any blood work done in the last six months		
Do you have **advanced directives** such as **living will** or **power of attorney**?		
Did you receive a copy of our **PATIENT RIGHTS**?		
Have you ever had a total joint replacement or surgical hardware implanted?		
Motion sickness / Car Sickness		

	YES	*NO*	**Explain Yes Answers**
High blood pressure			
High Cholesterol			
Chest pain or angina			
Congestive heart failure			
Irregular / skipped beat			
Heart Murmur			
Heart Attack			
Rheumatic Fever			
Mitral Valve Prolapse			
Pacemaker			
Defibrillator			
Circulatory disease			
Bronchitis			
Chronic cough			
Sleep Apnea / CPAP			
Shortness of breath			
Emphysema / COPD			
Asthma			
Pneumonia			
TB			
Diabetes			
Thyroid Problems			
Kidney Disease			
Bleeding Problems			
Anemia / Sickle Cell Disease			
Blood Clots			
Ulcers			
Hiatal Hernia			
Heartburn / Reflux			
Jaundice			
Hepatitis / Liver disease			
Muscular dystrophy / Polio/ Multiple Sclerosis			
Convulsions/Epilepsy/Seizures			
Stroke/Paralysis			
Migraine / Headaches			
Passed out recently/Dizziness			
Neck, Back or Disc Problems			
Arthritis			
Glaucoma			
Cancer			
HIV + / AIDS			
Psychiatric Problems, ie anxiety / depression			
Have you ever had MRSA (methicillin resistant staphylococcus aureus or VRE (vancomycin resistant enterococci)? Date:			

Surgical History:

(List all operations, and year performed)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE LIST ANY OTHER MEDICAL ILLNESSES OR CONDITIONS YOU MAY HAVE:

_____

_____

_____

_____OVER→

ALLERGIES OR INTOLERANCES TO MEDICATIONS, FOOD OR ENVIRONMENT:

□ **NO KNOWN DRUG ALLERGIES**

LIST BELOW WITH REACTIONS:

FOOD, DRUG or ENV.	REACTION

LATEX ALLERGY: □ YES □ NO

IN THE PAST YEAR HAVE YOU TAKEN: □ None
□ Diet Pills □ Steroids □ Blood Thinners
□ Chemotherapy □ Radiation Treatment □ Lasik Surgery

List all Medications, herbal, Vitamins:

MEDICATION	Dose	Freq	Last Dose nurse use only
Patient Signature:			
Date:			

Surgery Center Use only – do not write below this line:

Parenteral Fluids

Time	*Solution*	*volume*	*Lidocaine*	*Site / Drsg*	*Signature*	*D/C time*	*Jelco intact*	*Amt Infused*	*Signature*

Anesthesia

Physical Examination:

Heart – □ regular rate & rhythm _____

Lungs –□ Clear to auscultation _____
Airway: adequate potentially difficult
Teeth: normal loose chipped crowns bridge
dentures - U / L braces
Neck normal short fat thick
ROM: Poor / Good

Airway Class: I II III IV

Anesthesia Assessment:

_____
_____
_____

Signature: _____ ***Date:*** _____

ASA 1 2 3 4 E

Anesthesia Type: Gen MAC Bier Block
Other_____

□ Labs / CXR / EKG reviewed

Pre-op Orders:

□ Pepcid 20 mg IV
□ Reglan 10 mg IV
□ Scopolamine patch 1.5 mg behind ear
□ Zofran 4mg IV
□ Finger stick glucose
□ Obtain EKG within last 12 months or do on admit Y N
□ K+ level on chart or draw on admit if on a diuretic
□ Other_____
□ ok for surgery □ needs evaluation
Signature:_____ ***Date***_____

Reviewed with Patient:

□ NPO after Midnight ف Except Meds Height_____ Weight_____
ف Clear liquids until_____ Defibrillator ___ no
ف Leave valuable at home; jewelry Blood Thinners ___ yes ___ no
ف Transportation home ف Care given x 24 hours □ Pain scale reviewed
ف Time_____ ف Date_____ Blue Health Hx_____
□ Pt rights/responsibilities Advance Directives □ yes □ no
□ owned by Medical Associates Clinic / Mercy Heath Center
Signature:_____Date_____

Pain Assessment	*Pain Scale*
Location	___ Visual Analog Scale
Onset of Pain	_____ FLAC Scale
Duration of Pain	
What Relieves Pain	Explain to patient / s.o.
No Pain	

Pre-Op:

Arrival Time: _____

Preferred Name:_____

Accompanied By: _____

Mental Status: ❒ Alert, ❒ Oriented, ❒ Disoriented to person, place, time,

☐ **C**hanges in medical condition since H&P completed?
Dr. reviewed pre op tests with patient / significant other ❒yes ❒ no ❒ na
NPO Since:_____ B/P_____

Pulse_____ ☐ Regular Rate and Rhythm _____

Resp_____ ☐ Clear to auscultation _____
Temp_____ SaO2_____
□ Urine Pregnancy + -- N/A □ FBS ref. range 65-99 mg/dl _____
□ Pain assessment reviewed / Pain scale = _____

Nursing Note

_____
_____
_____
_____

Admission Signature **Date**

Patient Label