Tri-State Surgery Center
Patient History

Patient *Legal* Name: _____ **Height:** _____ **Weight:** _____**lbs** ____**kg**
Date of Birth: _____ **Preferred Name:** _____ **Age:** ____ **Sex:** ___ _____**BMI**
Medical Doctor: _____ **Email:** _____ ☐ **N/A**
Surgeon: _____ **Date of Surgery:** _____ ☐ **Yes** ☐ **No** **Permission to talk to family/friends regarding your care.**
Scheduled Procedure: _____
Reason for procedure: _____ **Phone number to reach you** _____

Dear Patient,

The Surgery Center team welcomes the opportunity to participate in you medical care! It is important that this form be completed 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 and look forward to providing you care. Please call 563-584-4514 with questions/concerns.

	YES	*NO*
Have you or anyone in your family ever had a problem with anesthesia, including nausea and vomiting or		
Malignant Hyperthermia?		
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 need assistance to walk? Cane____ walker____		
Do you exercise?		
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**? DPOA NAME: _____ DPOA #: _____		
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		
In the past year have you taken: ☐ None ☐ Diet Pills ☐ Steroids ☐ Blood Thinners ☐ Chemotherapy ☐ Radiation Therapy ☐ Lasik Surgery		

	YES	*NO*	**Explain Yes Answers**
High blood pressure			
High Cholesterol			
Chest pain or angina			
Congestive heart failure			
Irregular / skipped beat			
Heart Murmur			
Heart Attack			
Pacemaker			
Defibrillator			
Circulatory disease			
Bronchitis / Pneumonia			
Snoring or gasping for air			
Sleep Apnea / CPAP			
Shortness of breath			
Emphysema / COPD			
Asthma			
Parkinsons Disease			
Diabetes			
Thyroid Problems			
Kidney Disease			
Anemia / Sickle Cell Disease			
Blood Clots			
Ulcers			
Hiatal Hernia			
Heartburn / Reflux			
Hepatitis / Liver disease			
Muscular dystrophy / Polio/ Multiple Sclerosis			
Convulsions/Epilepsy/Seizures			
Stroke/Paralysis			
Passed out recently/Dizziness			
Cancer			
HIV + / AIDS			
Psychiatric Problems/anxiety / depression			
History of MRSA (Methacillin-Resistant Staphylococcus Aureus**)**			
History of C-Difficile?			
Personal or Family history of Bleeding Problems?			

Revised 11/12/18

Medical/Surgical History:
(List all operations and year performed as well as any medical illnesses or conditions you may have)

_____
_____
_____
_____
_____

Patient Signature: _____ Date: _____
Patient Rights and Responsibilities, Advance Directives, Notice of Privacy Practices and billing information are available on admission or on our website:
www.mahealthcare.com and choose Tri-State Surgery

Tri-State Surgery Center
Medication Reconciliation Form

☐ **No Known drug allergies**

Do you have a latex allergy? ☐ Yes ☐ No Reaction: ________________________
Do you have sensitivity to bananas, kiwi, avocado, or chestnuts? ☐ Yes ☐ No
Please list below allergies/intolerance to medications, food, or IV contrast:

Allergy	Reaction	Allergy	Reaction
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Medications currently taking including prescription, over the counter, vitamins, and herbal supplements

Medication & Dose	Frequency	Last Dose (To be completed by the NURSE ONLY)
	☐ Daily ☐ Twice Daily ☐ As Needed ☐ Other ___________	☐ Today ☐ Yesterday ☐ >1week ago ☐ Other __________
	☐ Daily ☐ Twice Daily ☐ As Needed ☐ Other ___________	☐ Today ☐ Yesterday ☐ >1week ago ☐ Other __________
	☐ Daily ☐ Twice Daily ☐ As Needed ☐ Other ___________	☐ Today ☐ Yesterday ☐ >1week ago ☐ Other __________
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	☐ Daily ☐ Twice Daily ☐ As Needed ☐ Other ___________	☐ Today ☐ Yesterday ☐ >1week ago ☐ Other __________

SURGERY CENTER USE ONLY – DO NOT WRITE BELOW THIS LINE

Resume Medications: ☐ Yes ☐ No Pre-Op RN initials: _____ (initials)
Hold: ____________________________________ ☐ N/A

Prescriptions Given At Discharge

New Prescription Given	Last Dose Given

Patient/Representative Signature: ___________________________________
Recovery Nurse Signature: ____ Patient Label