Surgical Care Center

PRESURGICAL ASSESSMENT

SAME DAY SURGERY

(PLEASE USE INK)

Patient's Name: _____BIRTHDATE_____

Reason for admission: _____

Family Physician: _____Patient's Phone number: _____Cell _____

ALL ALLERGIES (INCLUDING LATEX ALLERGIES/SENSITIVITES AND ALL ABNORMAL & ADVERSE DRUG REACTIONS) **REACTION**

_____

_____

_____

_____

_____

PLEASE LIST ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS PRESENTLY TAKEN, INCLUDING ANY EYE DROPS, ON ATTACHED MEDICATION RECONCILIATION FORM.

PLEASE LIST PRIOR SURGERIES, HOSPITALIZATIONS AND DATES: _____

_____

_____

_____

Please check each question yes or no. If you do not understand, place a (?) question mark on one of the columns. Any yes answers will be reviewed by a nurse or anesthesiologist.

	YES	NO		YES	NO
Cold/sore throat past 2 wks.			Low blood pressure / High blood pressure (if yes, circle)		
Chronic or frequent coughs			Chest pain, angina, and heart attack		
Asthma, hay fever, croup			Congestive heart failure		
Bronchitis, pneumonia			Mitral valve prolapsed		
Sleep Apnea			Fast or irregular heartbeat		
Emphysema / Shortness of breath			Pacemaker		
Difficulty breathing through your nose			Anemia, sickle cell anemia		
Any other lung problems / TB			Jaundice, hepatitis, cirrhosis		
Do you smoke, or use tobacco?			Infectious mononucleosis		
How much? How long?			Hiatal Hernia, ulcer		
Quit? When?			Gall bladder problems		
Do you drink alcohol?			Back, neck pain or injury		
How much? How often?			Slipped disk, sciatica		

	YES	NO		YES	NO
Do you use drugs i.e. cocaine/marijuana?			TMJ – Diff. opening mouth widely		
History of Cancer			Muscular problems, Parkinson's disease		
Rheumatic fever, heart murmur			Convulsions, Epilepsy		
Glaucoma			Stroke, Paralysis		
Have you ever been on steroids?			Have you ever had a blood transfusion?		
(i.e. cortisone, prednisone) If so, when?			If so, when?		
Dizziness			Have you or your family had any bleeding problems?		
Meningitis, polio			**Reaction to local or general anesthesia?**		
Thyroid problems			**Has relative had reaction to anesthesia?**		
Kidney or bladder problems			Date of last general anesthesia		
Low blood sugar			Glasses or contact lenses		
Diabetes (high blood sugar)			Dentures, bridges U_____L_____		
Any psychiatric problems			Caps, crowns		
Other:			Braces		
			Chipped Teeth		
			Loose teeth		
Hearing aid			Missing teeth		
			A physical prosthesis		
FEMALES: poss. of being pregnant?					
Illness during pregnancy?			Claustrophobic issues		
Heavy menstrual periods?					
Last menstrual period date:			Please indicate race or ethnicity:		

What questions can I answer for you? _____

_____

_____

I have answered the above questions concerning my health to the best of my knowledge.

Signed: _____ Relationship, if other than patient: _____

Nurse Signature: _____

SURGICAL CARE CENTER

MEDICATION RECONCILIATION

Medication Name Include: OTC, vitamins, herbal supplements	Dosage	Frequency or Time	Resume	What drug is used for	Staff initials

Anesthesia Type: General MAC Local Other _____

Medications reviewed with patient. RN Signature _____

I verify that the above list of medications is complete and accurate to the best of my knowledge.

Patient Signature_____

The reconciliation and decision to continue or omit with reason, the use of these medications as appropriate to the care of the patient, is made by the prescribing physician. Vitamins and herbal supplements are not reconciled unless specifically ordered by physician.

Return Visit Update

No Change Change listed Date: _____ Signature:_____