

ASI SURGERY CENTER, INC

PATIENT QUESTIONNAIRE

Name Preference: Primary Language: Age: Height: Weight: BP: Pulse: Temp: Person taking you home: Their contact number: How much time do they need to get back to the surgery center to pick you up?

Yes No

- Do you have a history of Endocarditis?
Do you have a history of heart valve replacement?
Do you have artificial joints? Date of replacement:
Do you have a pacemaker/defibrillator?
Do you have any drug or food allergies? List them/reaction:
Are you allergic or sensitive to Latex?
Did you have any of the following test done prior to surgery (please circle):
EKG Chest X-Ray Bloodwork Other X-Rays or tests:
Have you ever taken cortisone or had a cortisone injection?
Do you drink alcohol? How much? per day/week/month?
Do you use any recreational drugs - marijuana, iv drugs, pills, etc?
*This is for your complete medical care only. No legal ramifications will result.
Have you had a cold or other infections in the last two (2) weeks?
Have you taken any aspirin, ibuprofen, Alka-Seltzer, Advil, Motrin, Aleve or other NSAIDS in the last 5 days?
Do you get headaches or back pain? How often?
Have you or any member of you family had any problems with anesthesia?
Explain:
Are you pregnant or breast feeding?
If you are on your menstrual cycle, have you removed any tampons?

Do you have:

Neurological Problems Diabetes Hypertension Bleeding Problems Hepatitis Asthma Fainting/Dizziness Smoking Heart Problems Liver problems/Jaundice Rheumatic Fever Cold Sores/Herpes Other medical problems:

List any medications, injections, vitamins, pills, herbal or homeopathic remedies:

List major illnesses, operations and hospitalizations and approximate dates:

Do you have an Advance Directive? Yes No

Primary Care M.D.: Phone number: Pre-Op Call Made by: LVN/RN Date/time:

Patient Signature: Date/time:

RN Signature: Date/time:

No Change from pre-operative assessment.

MD Signature: Date/time:

Pt Name
DOB