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? ______________
Pre-Op Call Made by: _____________________ LVN/RN **Date/time:** _____________________

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	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Fainting/Dizziness	☐ Yes	☐ No	Smoking	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No
Liver problems/Jaundice	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Cold Sores/Herpes	☐ Yes	☐ No

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: ___________________
Patient Signature: ______________________________ **Date/time:** ___________________

RN Signature: __________________________________ **Date/time:** ___________________
☐ No Change from preoperative assessment ☐ Procedure verified by patient
☐ Patient is aware local anesthesia will be administered ☐ Site marking verified by patient
MD Signature: __________________________________ **Date/time:** ___________________

Pt Name
DOB