ASI SURGERY CENTER, INC

PATIENT QUESTIONNAIRE

Name Preference: _____ Primary Language: _____

Age: _____ Height: _____ Weight: _____

BP: _____ Pulse: _____ Temp: _____ SPO2:_____

Person taking you home (general anesthesia/sedation patients only): _____

contact number: _____ How much time do they need to pick you up? _____

Pre-Op Call Made by: _____ 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: _____

Yes	No	NA	
☐	☐	☐	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 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: _____

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Pt Name
DOB