Premier Surgical Center Label

Info from: □ Patient □ Family □ Old Chart Patient Name:

PRE-OP SCREENING

Height:_____Weight:_____ BMI _____ If you are female, could you be pregnant? _____ LMP_____
SURGICAL HISTORY/RECENT HOSPITALIZATIONS (Type of surgery/hospitalization & Date):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have an Advanced Directive/Living Will (directions for medical care when you are unable to speak for yourself)? □Yes □No
ALLERGIES: (Meds/Latex/IV Dye/Iodine/Foods) _____
_____

MEDICAL HISTORY: Please check or circle all that apply.

Cardiovascular

□ High Blood Pressure
□ Heart Disease
□ Heart Attack
When:
□ Angina/Chest Pain
□ Congestive Heart Failure
□ Palpitations/ Irregular Heart Rhythm
□ A Fib
□ Heart Stents
□ Heart Valve Repair/ Replacement
□ Pacemaker
□ Defibrillator
□ Stroke/TIA/ Mini Stroke
□ Weakness/Deficit
Where:_____
□ Rheumatic Fever
□ Heart Murmur
□ Elevated Cholesterol
□ Circulation Problems
□ Swelling Feet/Ankles
□ DVT/PE/Blood Clot

Respiratory

□ Asthma
□ Bronchitis
□ Pneumonia
□Upper Respiratory Infection
□ COPD
□ TB (Tuberculosis) or Exposure to TB
□ Sleep Apnea
□ CPAP machine use
□ Oxygen use
Liters _____
Continuous/As needed

Metabolic

□ Diabetes
Controlled with:
Insulin/Medication/Diet
□ Thyroid Disease Hyper/Hypo
□ Liver Disease
□ Jaundice

Neuro

□Dizziness/Fainting
□Depression/Anxiety
□Seizure, Last:_____
□ Migraines

G I

□ GERD / Reflux
□ PUD / Ulcers
□ Hiatal Hernia
□ Gastroparesis
□ Polyps
□ Diverticular Disease
□ Crohn's Disease
□ IBS(Irritable Bowel)
□ Colon Cancer

Skin

□ Rash
□ Cellulitis
□ MRSA/ Hx of
□ Eczema/Psoriasis
□ Draining Wounds

GU

□ Kidney Disease/ Renal Insufficiency
□Kidney/Renal Failure
□Dialysis
□ Bladder or Urinary Problems
□ Urinary Retention
□ Incontinence
□Uterine/Prostate Ca
□ BPH/Enlarged Prostate

Premier Surgical Center Label

Musculo/Skeletal

□ Injuries/Surgeries to Muscles/Bones
□ Artificial Joint or Metal/Hardware in Joint(s) Where: _____
□ Arthritis / Weakness Where: _____
□ Muscle Disease Type: _____
□ Numbness/Paralysis
□ Use of Cane/Walker/Crutches/Wheelchair

Social

□ Tobacco Use:
_____ Pack(s) Per Day # of Years: _____
□ Alcohol Use: Social/Daily/Weekends
Quantity: _____
□ Intravenous Drugs

Do you have implants in your body, either silicone or metal? If so, where? _____

Have you/a relative been out of the country in the last 3 months? □Yes □No When? _____ Where? _____

Have you or any of your relatives ever had a problem with anesthesia? _____ If yes, explain _____

Are you prone to motion sickness? _____

Other

□COVID 19
□ Hepatitis B
□ Hepatitis C
□ HIV
□ Transfusions
□ Cancer _____Chemo/ Radiation
□ Blood and/or Bleeding Disorder
□ Anemia
□Sickle Cell
□Immunizations:
Flu/Pneumonia/Shingles/COVID 19
When? _____

Head & Neck

□ TMJ/Jaw Problems
□Caps/Implant/Dentures Where: _____
□ Chipped/Loose Teeth Where: _____
□ Vision Impairment
□Cataracts/Surgery
□ Glaucoma/Macular Degeneration
□Use of Glasses or Contact Lenses
For: Distance/Reading
□ Hearing Loss/Use of Hearing Aides
□ Language Barrier/Speech Barrier/ Interpreter needed

_____ _____
Patient Signature (or Authorized Representative) Date

□ Reviewed & Updated _____ _____
Nurse Signature Date

_____ _____
Patient Signature (or Authorized Representative) Date

□ Reviewed & Updated _____ _____
Nurse Signature Date

_____ _____
Patient Signature (or Authorized Representative) Date

□ Reviewed & Updated _____ _____
Nurse Signature Date

TO BE COMPLETED THE DAY OF SURGERY

I certify that I had nothing to eat or drink since: **I certify that the following individual will drive me home:**

_____am/pm on _____ **_____** **_____**
Date **Driver's Name/Phone #** **Patient Initials/Date**

_____am/pm on _____ **_____** **_____**
Date **Driver's Name/Phone #** **Patient Initials/Date**

_____am/pm on _____ **_____** **_____**
Date **Driver's Name/Phone #** **Patient Initials/Date**

***Please note: Premier Surgical Center will not be held responsible if the individual stated above does not drive you home.**

_____ Patient Initials/Date