Medical Information Database/Pre-Op Assessment

Name ____ **Date** ___________

Reason for seeing physician ____
Referring Physician ____
Were you seen in the E.R.? YES / NO If YES, which hospital ________________
Date of accident or injury ____
Primary Care Doctor, Pediatrician, Family Doctor, and GYN, if you have one
____

Previous Medical History

Do you have a latex allergy/Sensitivity? YES NO
If YES, what type of reaction ____

List all known drug allergies: ____
____

List all medications you are taking and the reason (including Aspirin, Ibuprofen, Motrin, NSAID, Goody Powder, Vitamins, Herbal Medications, etc.) Include dose and frequency.
____
____
____
List any medications you cannot take _______________________________________
____

Accurate Height and Weight____

Immunizations

Please indicate date (month and year) of last Immunization

Tetanus Booster ________________
DPT _________________________
MMR _________________________
Covid-19 Dose 1 _______________

Chicken Pox _____________________
Hepatitis B ______________________
Polio ___________________________
Covid-19 Dose 2 __________________

Covid-19 Booster ______________

Current Medical Problems

YES NO
____ ____ High Blood Pressure
____ ____ Cancer
____ ____ Immune Deficiency
____ ____ Lung Disease
____ ____ HIV/AIDS
____ ____ Breast Disease

YES NO
____ ____ Cardiac Disease/Heart Attack
____ ____ Diabetes
____ ____ Kidney Disease
____ ____ Substance Abuse
____ ____ Hepatitis A/B/C
____ ____ DVT / PE

If other, please explain ____

Review of Systems

YES NO
_____ _____ Fever
_____ _____ Sinusitis
_____ _____ Seizures
_____ _____ Skin lesions that are changing
_____ _____ Excessive bleeding/easy bruising
_____ _____ Glasses
_____ _____ Shortness of breath
_____ _____ Sleep Apnea
_____ _____ Diarrhea
_____ _____ Jaundice
_____ _____ Ear aches
_____ _____ Heartburn
_____ _____ Blood in bowel movements
_____ _____ Depression or Anxiety

YES NO
_____ _____ Vision Problems
_____ _____ Chest Pain
_____ _____ Constipation
_____ _____ Coughing up blood
_____ _____ Chills
_____ _____ Sore Throat
_____ _____ Weakness/Numbness
_____ _____ Reflux
_____ _____ Blood in urine
_____ _____ Weight loss or gain
_____ _____ Wheezing/asthma
_____ _____ Fainting
_____ _____ Difficulty urinating
_____ _____ Difficulty healing

Have you tested positive for Covid-19 within the past year? YES NO
If YES, when was your most recent positive test? ____

Previous Hospitalizations/Pregnancies

Date (month/year)	Reason for Hospitalization
_____________________	____
_____________________	____
_____________________	____
_____________________	____

Past Surgical History

Date (month/year)	Procedure	Difficulty with Anesthesia
________________	_________________________	YES NO
________________	_________________________	YES NO
________________	_________________________	YES NO
________________	_________________________	YES NO
________________	_________________________	YES NO
________________	_________________________	YES NO

Would you object to a medically necessary blood transfusion? YES NO

Last menstrual period_________________ Any chance of being pregnant______________

Social History

Do you use tobacco/nicotine products of any kind? YES NO Amount/Frequency ________________

Do you drink alcohol? YES NO Amount/Frequency ________________________

Do you use illegal drugs? YES NO Amount/Frequency ________________________

Occupation ____

Living Situation (who is in your household) ____
____

Family History

Please X YES or NO and list the relationship

	YES	NO	Relationship
High Blood Pressure	____	____	___________________
Diabetes	____	____	___________________
Breast Cancer	____	____	___________________
Melanoma	____	____	___________________
Other Cancers	____	____	___________________
DVT / PE	____	____	___________________

Date of most recent lab work, EKG, x-ray or diagnostic tests______________________________________
Location______________________________________
Phone______________________________________

Please list the two most important questions we can answer for you at your initial Consultation:

____

____

____

____

NOTES:

TO BE COMPLETED BY OFFICE STAFF:

Pre-Operative:

____ CBC

____ BMP

____ H&H

____ PT

____ PTT

____ UA Pregnancy

____ CXR

____ EKG

____ Other: ______________________________

Orders Mailed to Patient: ___________________

Order Given to Patient: _____________________

Reviewed on ____________________ By ___________________________________

Reviewed and Updated on ____________________ By ________________________

* Instructed patient to fax results to surgery center: YES NO

Pre-Operative assessment completed by: ________________________

Date: ________________________

Anesthesia reviewed by: ________________________ MD

Date: ________________________

Patient is approved for outpatient surgery YES NO

ASA I ASAII ASAIII (only with anesthesia consultation)