Memorial Same Day Surgery Centers

Pre Screening Health History

DOS:_____

DR._____

PATIENT NAME:_____**(CONFIRMED__)**
DOB:_____ **AGE:** _____ **GENDER: M/F**
PROCEDURE: _____
_____
PT. PHONE #:_____ **SECONDARY # :** _____
HEIGHT: _____ **WEIGHT:** _____ **LBS**

PRIMARY CARE PHYSICIAN: _____**(Medical Clearance Y/N)**
LAST VIST:_____ **PHONE NUMBER:**_____
SPECIALIST: _____ **LAST VIST:**_____ **PHONE:**_____

ALLERGIES TO MEDS. YES NKDA(NO)
(IF YES PLEASE SEE MEDICATION SHEET)
LATEX/RUBBER: YES NO
(IF YES SEE LATEX QUESTIONAIRE)
FOOD ALLERGIES: YES NO
_____

ANESTHESIA
HAVE YOU EVER HAD PROBLEMS WITH ANESTHESIA? YES NO
NAUSEA: YES NO
FAMILY HISTORY: YES NO
KNOWN DIFFICULT INTUBATION: YES NO

PREVIOUS SURGERIES **YEAR**
_____
_____
_____
_____
_____
_____

PERSON FILLING OUT FORM:_____**DATE:**_____
PERSON DRIVING PATIENT HOME: _____

NOTES:

PATIENT LABEL

PLEASE CIRCLE YES/NO

CARDIOVASCULAR

HIGH BLOOD PRESSURE	YES	NO
HIGH CHOLESTEROL	YES	NO
CHEST PAIN	YES	NO
HEART ATTACK	YES	NO
STENT/ ANGIOPLASTY	YES	NO
HEART MURMUR	YES	NO
MITRAL VALVE PROLAPSE	YES	NO
IRREGULAR HEART BEAT	YES	NO
OPEN HEART SURGERY	YES	NO
PACEMAKER	YES	NO
DEFIBRILLATOR	YES	NO

RESPIRATORY

ASTHMA/WHEEZING	YES	NO
EMPHYSEMA/COPD	YES	NO
OXYGEN AT HOME	YES	NO
SLEEP APNEA	YES	NO
CPAP	YES	NO
TB / POSITIVE PPD	YES	NO
DO YOU SMOKE	YES	NO
MORE/LESS THAN ONE PACK	YES	NO
RECENT FEVER/COLD/SORE THROAT-COUGH	YES	NO

NEUROLOGY

STROKE/TIA/CVA	YES	NO
SEIZURES/EPILEPSY	YES	NO
DEMENTIA/MEMORY LOSS	YES	NO
MIGRAINES/HEADACES	YES	NO
ANXIETY/PANIC ATTACKS	YES	NO
DEPRESSION	YES	NO

MUSCULAR SKELETAL

ARTHRITIS	YES	NO
TMJ/ JAW	YES	NO
BACK/NECK/DISC	YES	NO
PARALYSIS	YES	NO
WALKER/CANE	YES	NO
WHEELCHAIR	YES	NO

GI

HIATAL HERNIA	YES	NO
GERD	YES	NO
HEART BURN	YES	NO
LIVER DIEASE	YES	NO
HEPATITIS	YES	NO

GU

KIDNEY	YES	NO
BLADDER	YES	NO
INCONTINENT	YES	NO
DIALYSIS	YES	NO
SHUNT	YES	NO

(WHAT DAYS?) _____

ENDOCRINE

DIABETES	YES	NO
INSULIN	YES	NO
ORAL MED	YES	NO
DIET	YES	NO
HIV	YES	NO
THYROID	YES	NO

FEMALE

LMP _____

HYSTERECTOMY	YES	NO
MENOPAUSE	YES	NO
BREASTFEEDING	YES	NO
POST PARTUM	YES	NO

PEDIATRICS

FULL TERM	YES	NO
PREMATURE	YES	NO
CONGENITAL BIRTH DEFECTS:	YES	NO
DEVELOPMENTAL DELAY	YES	NO

_____

OTHER

GLASSES	YES	NO
CONTACT LENSES	YES	NO
HEARING AID	YES	NO
DENTURES/PARTIAL	YES	NO
DENTAL WORK	YES	NO
BODY PIERCINGS	YES	NO
BLEEDING DISORDERS	YES	NO
CANCER	YES	NO
AUTO IMMUNE DISEASE	YES	NO
WOUNDS/SORES/INFECTIONS	YES	NO

INSTRUCTIONS: NPO ___ MEDS TO TAKE ___ NO LOTION ___ ATTIRE/SOCKS ___
NO JEWLERY ___ RIDE___ ARRIVAL TIME PER PHYSICIAN___ PER FACILITY___
FACILITY LOCATION ___ INS. CARD/I.D. ___

PATIENT SIGNATURE:_____ **DATE:** _____

ANESTHESIA REVIEW:_____ **DATE:** _____