GENERAL PREOPERATIVE INFORMATION

FOR

PACIFIC SURGERY CENTER

1. **SEE** your doctor for medical clearance one week prior to surgery. **ASK** your doctors office to FAX the information to ***Pacific Surgery Center*** as soon as possible.

2. **DO NOT** eat or drink anything after midnight prior to surgery and the morning of your surgery.

3. **TAKE** all necessary prescribed medications (heart, blood pressure, and diabetes) the morning of surgery with a small sip of water.

4. **BRING** inhalers and insulin and other medications with you. **WEAR** dentures or hearing aids.

5. **BRING** all INSURANCE CARDS, the completed forms to ***Pacific Surgery Center*** with you on the day of surgery.

6. **MAKE** arrangements for a responsible adult to drive you home.

7. **DO NOT** wear make-up to surgery and leave valuables at home.

8. You **MAY** park in the rear of the building in areas with no sign or designated for ***Pacific Surgery Center,*** or you **CAN** load and unload passengers in the green zone in front of the building.

9. CALL your ophthalmologist's office for surgery arrival time.

If you have any questions or concerns, please call us at:

818-567-0348

PLEASE FILL OUT & TAKE TO PACIFIC SURGERY ON THE DAY OF SURGERY

PACIFIC SURGERY CENTER PATIENT QUESTIONNAIRE

PATIENT NAME: _____ AGE: _____ SURGERY DATE: _____

HEIGHT: _____ WEIGHT: ____ PHONE: HM: _____CELL_____WORK_____

1. ARE YOU ALLERGIC TO ANYTHING? YES NO IF YES, TO WHAT AND DESCRIBE REACTION_____

2. DO YOU WEAR? ___DENTURES ___CONTACT LENSES ___HEARING AIDS OTHER? : _____

3. DO YOU SNORE? YES NO DO YOU HAVE SLEEP APNEA? YES NO, IF YES DO YOU USE A CPAP MACHINE? YES NO

4. LIST ANY MEDICINE, INJECTIONS, OR PILLS YOU TAKE: _____
5. HAVE YOU HAD ANY PROBLEMS WITH YOUR HEART, BLOOD PRESSURE OR HAVE YOU HAD A STROKE? YES NO IF YES, PLEASE DESCRIBE: _____

6. DO YOU HAVE DIABETES? YES NO, IF YES DO YOU TAKE INSULIN OR PILLS, OR IS IT CONTROLLED BY DIET? _____

7. HAVE YOU HAD ANY CONVULSIONS, BLACKOUT SPELLS, OR SEVERE HEADACHES? YES NO

8. HAVE YOU EVER HAD JAUNDICE, HEPATITIS, OR A TRANSFUSION REACTION? YES NO

9. HAVE YOU TAKEN STEROIDS OR CORTISONE WITHIN THE LAST YEAR? YES NO
IF YES, WHEN AND FOR WHAT REASON? _____

10. HAVE YOU HAD ANY PROBLEMS WITH BLEEDING OR BRUISING EASILY? YES NO

11. HAVE YOU, OR ANY BLOOD RELATIVE, HAD ANY REACTION TO A LOCAL OR GENERAL ANESTHESIA? YES NO
IF YES, DESCRIBE THE REACTION _____

12. ARE YOU PREGNANT? YES NO DO YOU SMOKE? YES NO IF YES, HOW MUCH? _____

13. DO YOU DRINK ALCOHOL? YES NO IF YES, DO YOU DRINK DAILY? YES NO

14. HAVE YOU HAD A RECENT COLD OR COUGH? YES NO IF YES, WHEN? _____

15. DO YOU HAVE ANY BREATHING PROBLEMS, SUCH AS ASTHMA OR CHRONIC LUNG DESEASE? YES NO

IF YES, PLEASE EXPLAIN: _____

16. DO YOU TAKE ASPIRIN, BUFFERIN, EXCEDRIN, BABY ASPIRIN OR ANY OTHER ASPIRIN PRODUCT? YES NO

IF YES, WHEN DID YOU LAST TAKE IT? _____
17. LIST THE OPERATIONS YOU HAVE HAD DURING YOUR LIFE: _____
_____

18. LIST ALL THE MAJOR ILLNESSES YOU HAVE HAD IN YOUR LIFE, OTHER THAN THE USUAL CHILDHOOD DISEASES:
_____

19. ANY UNUSUAL HEALTH PROBLEMS YOUR DOCTOR SHOULD KNOW ABOUT? _____
_____

20. WHAT PROBLEMS WITH YOUR VISION OR EYES DO YOU EXPECT THIS SURGERY TO HELP? (PLEASE CHECK ALL THAT APPLY)

__SEE TELEVISION __READ SMALL PRINT __READ STREET SIGNS __PASS DMV VISION TEST

__SEE TO WRITE __SEE TO SEW __PLAY GOLF OR OTHER SPORTS __ALLEVIATE DAYTIME GLARE

__ALLEVIATE NIGHTTIME GLARE OTHER (PLEASE SPECIFY _____

_____ _____ _____

PATIENT NAME (PRINTED) SIGNATURE DATE REV 06/12

PACIFIC SURGERY CENTER
2829 West Burbank Boulevard
Burbank, CA 91505-2300
(818)567-0348
FAX (818) 567-2859

Today's Date:_____

PATIENT REGISTRATION

Patient Information	Miss Mrs. Mr. Ms.	Last Name	First Name	Middle Initial	Age	Birth date
	Street Address		City	State	ZIP Code	
	Home Phone		Business Phone	Social Security Number		
Emergency Contact Information	Miss Mrs. Mr. Ms.	Full Name		Relationship To Patient		
	Street Address		City	State	ZIP Code	
	Home Phone		Business Phone	Cell Phone		
Primary Care Physician	Physician's Name		Phone Number			
Primary Insurance	Medicare? ☐ yes ☐ no	Medicare Number	Medi-Cal? ☐ yes ☐ no	Medi-Cal Number		
	PRIVATE INSURANCE: Name of Insurance Company			Name of Policy Holder		
	Insurance Company Phone		Certificate Number	Group Number		
Secondary Insurance	Medicare? ☐ yes ☐ no	Medicare Number	Medi-Cal? ☐ yes ☐ no	Medi-Cal Number		
	PRIVATE INSURANCE: Name of Insurance Company			Name of Policy Holder		
	Insurance Company Phone		Certificate Number	Group Number		

PLEASE FAX OR BRING THIS FORM, WITH COPIES OF INSURANCE CARDS, TO
PACIFIC SURGERY CENTER