BLUE RIDGE SURGERY CENTER: PREADMISSION RECORD

FOR OFFICE USE ONLY			
NAME:			
PROCEDURE:			
SURGEON:			
CAN BLUE RIDGE SURGERY CENTER LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? ☐ YES ☐ NO			

PATIENTS PLEASE FILL OUT HISTORY SECTION BELOW COMPLETELY

IF CHILD, PARENT'S NAME:		**SEX: M ☐ F ☐**	Weight: _____ Height: _____
M S W D	**DOB:**	**AGE:**	**FAMILY PHYSICIAN**
ALLERGIES:			

MEDICAL HISTORY			**PREVIOUS SURGERY TYPE AND APPROXIMATE DATE**
PLEASE CHECK IF YOU HAVE OR HAVE EVER HAD:			
☐ HEART TROUBLE	☐ BLEEDING DISORDER		
☐ HIGH BLOOD PRESSURE	☐ DIABETES		
☐ LOW BLOOD PRESSURE	☐ SICKLE CELL DISEASE / TRAIT		
☐ CHEST PAIN/ ANGINA	☐ DIGESTIVE DISORDER		
☐ STROKE	☐ INJURED BACK/NECK/NOSE		Date of last Menstrual Period?
☐ EPILEPSY/SEIZURES	☐ ARTHRITIS		Any possibility that you are pregnant? ☐ YES ☐ NO ☐N/A
☐ BRONCHITIS OR PERSISTENT COUGH	☐ DENTURES/BRIDGES/CAPS/ LOOSE TEETH		Patient's present complaint:
☐ LUNG TROUBLE/TB/ASTHMA	☐ SLEEP APNEA		
☐ KIDNEY TROUBLE	☐ LATEX ALLERGY		☐Do you have a pacemaker?
☐ LIVER DISEASE/ HEPATITIS/JAUNDICE	☐ BLOOD CLOT		☐Do you have an internal cardiac defibrillator? ☐History of infectious disease i.e., TB, HIV, Hepatitis, MRSA
☐ THYROID DISEASE	☐ GLASSES / CONTACTS?		
☐ MENTAL DISORDER	☐ HAVE YOU OR FAMILY HAD REACTION TO PRIOR ANESTHESIA		☐ Any religious/cultural practices that need to be a part of your care?
☐ PHYSICAL DISABILITIES	☐ CURRENT INFECTIONS		Do you have a living will or advanced directive?☐ YES ☐ No
☐ RECENT WEIGHT CHANGE?	☐ HEARING AID?		If so, please bring a copy to place in your chart. If not we
☐ DO YOU DRINK ALCOHOL?	☐ RECREATIONAL DRUGS?		will be glad to provide you with information.
☐ SMOKE _____ Packs Per Day X _____ YEARS			EMERGENCY NAME & PHONE #:
☐ HISTORY OF PREMATURITY OR OTHER BIRTH PROBLEMS?			