Date of Procedure_____
Doctor: _____

Tri-City Surgery Center
Patient Questionnaire/Medical History

Patient Label

Phone: _____

Name: _____ Age: _____ Height: _____ Weight:_____ BMI:_____

Please list previous surgeries: _____

Have you ever had a problem with anesthesia? ☐Yes ☐No Explain_____

Have any of your blood relatives ever had Malignant Hyperthermia or Anesthesia Problems? ☐Yes ☐No_____

Have you had any E.R. visits or been hospitalized in the last year? Why? _____

Allergies ☐**No known Allergies** ☐**List all allergies on the back of this form ◄** (*Circle this in Red if you have allergies*)
Please list all medications, vitamins, supplements and over the counter medications or attach a medication list.

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Have you had any of the following conditions below? (√= yes)

Cardiovascular
☐ High Blood Pressure ☐Angina/Chest Pain
☐ Heart Attack / MI When_____
☐ Pacemaker/Defibrillator
☐ Other Heart Problems List_____
_____
☐ Do you exercise? _____
☐ Can you climb a flight of stairs without becoming short of breath?
☐ Bleeding, Clotting or Blood Disorders List_____
☐ Cardiologist_____

Respiratory
☐ Asthma ☐ COPD
☐ Recent cold/sinus infection /bronchitis
☐ Use Home O2 ____Liters ☐HS ☐24hrs
☐ Other Lung/Breathing Problems List_____

Obstructive Apnea Risk (√= yes)
☐ Sleep Apnea ☐ Use CPAP/BIPAP
☐ Do you snore loudly

Gastrointestinal/Digestive
☐ Hiatal Hernia ☐ Stomach ulcer
☐ GERD/Acid Reflux
☐ Other Gastrointestinal Problems List_____

Colonoscopy Patients:
How long ago was your last colonoscopy?
☐0-3 years ☐More than 3yrs. ☐Never had
Did you have polyps? ☐Yes ☐No ☐Unsure

Endocrine
☐ Diabetes Type____ ☐ Insulin Pump
☐ Thyroid problems
☐ Other_____

G.U.
☐ Kidney Problems _____
☐ Urinary/Bladder Problems _____
☐ Liver Problems/Jaundice_____
List_____

Males: ☐Prostate Problems _____

Females:
☐Hysterectomy ☐Post-Menopause

Neuro
☐ Stroke/TIA When _____
☐ Seizures Date of last _____
☐ Psychological problems _____
☐ Depression or Anxiety
☐ _____
☐ Extremity numbness/tingling_____

Musculoskeletal
☐ Arthritis -Type_____
☐ Difficulty opening mouth
☐ Difficulty tilting head back
☐ Any muscle or bone problems?
_____

Additional history
☐ Cancer Type_____ When _____
_____
☐ Auto-Immune Disorder Type_____

Lifestyle (√= yes)
☐Do you smoke? ☐Did you ever smoke?
How much/ how long? _____
Year quit _____
☐ Do you drink alcohol?
How much/how often? _____
☐ Do you use recreational drugs?
What type? _____
Date of last use _____
☐Do you feel safe at home? (√= yes)
(This is a domestic violence question)

Communicable Diseases
☐HIV When _____Treated (Y/N)
☐Hepatitis ***Type*** _____
When _____Treated (Y/N)
☐MRSA When _____Treated (Y/N)
☐TB When _____Treated (Y/N)
☐C-Diff When _____Treated (Y/N)

Please list any other medical problems
_____
_____

Nurse: _____

Time: _____ Date: _____

At Tri-City Surgery Center we are dedicated to making your experience here one of excellence. Please tell us of any religious, cultural or communication concerns. _____

PRE-Op Vitals	Temp.	B/P	B/P	P	RR	SPO2%

Anesthesia Care Provider Physical Exam: **Habitus:** ☐**Normal** ☐**Thin** ☐**Obese** ☐**Muscular** **Head & Neck motion:** ☐**Normal** ☐**Abnormal**

Chest: ☐**Clear** ☐**Abnormal** **Airway: MP**_____ **Heart** ☐**RRR** ☐**M** ☐**Abnormal** **NPO**_____ **Blood Glucose Result**_____

Anesthesia Care Provider Signature_____**Date/Time**_____

☐**C/S** ☐**Local**

TRI CITY SURGERY CENTER

Tri-City Surgery Center

ALLERGY FORM

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO TRI-CITY SURGERY CENTER

□ **LATEX** **Reaction:** □Itching/Rash/Hives □Swelling □Difficulty breathing □Anaphylactic Shock □Other____________

□ **ADHESIVE** **Reaction:** □Itching/Rash/Hives □Other____

MEDICATION	REACTION
______________	□Itch/Rash/Hives □Swelling □Difficulty Breathing □Anaphylactic Shock □Other______ □*N&V
______________	□Itch/Rash/Hives □Swelling □Difficulty Breathing □Anaphylactic Shock □Other______ □*N&V
______________	□Itch/Rash/Hives □Swelling □Difficulty Breathing □Anaphylactic Shock □Other______ □*N&V
______________	□Itch/Rash/Hives □Swelling □Difficulty Breathing □Anaphylactic Shock □Other______ □*N&V
______________	□Itch/Rash/Hives □Swelling □Difficulty Breathing □Anaphylactic Shock □Other______ □*N&V
______________	□Itch/Rash/Hives □Swelling □Difficulty Breathing □Anaphylactic Shock □Other______ □*N&V
______________	□Itch/Rash/Hives □Swelling □Difficulty Breathing □Anaphylactic Shock □Other______ □*N&V
______________	□Itch/Rash/Hives □Swelling □Difficulty Breathing □Anaphylactic Shock □Other______ □*N&V
______________	□Itch/Rash/Hives □Swelling □Difficulty Breathing □Anaphylactic Shock □Other______ □*N&V
______________	□Itch/Rash/Hives □Swelling □Difficulty Breathing □Anaphylactic Shock □Other______ □*N&V
______________	□Itch/Rash/Hives □Swelling □Difficulty Breathing □Anaphylactic Shock □Other______ □*N&V

SENSITIVITIES:

____

***N&V=Nausea & Vomiting**