Date of Procedure____________
Doctor:____________________

Tri-City Surgery Center

Patient Questionnaire/Medical History

Patient Label

Phone:____________________

Name:____ Age:______ Height:__________ Weight:_________

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
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
☐ 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___________________
☐ Thyroid problems
☐ Other____________________________

G.U.

☐ Kidney Problems _________________
☐ Urinary 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/ have you ever smoked?
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 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 Blood Glucose Result_________

Anesthesia Care Provider Signature____Date/Time_____________________

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☐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
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______________☐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