Patient Name: ___________________

____

ALGONQUIN ROAD SURGERY CENTER, LLC
Patient Centered. Extraordinary Care.

PLEASE ANSWER THE FOLLOWING QUESTIONS PRIOR TO SCHEDULING PROCEDURE:

Do you have a Cardiac Defibrillator, Narcolepsy, ACTIVE MRSA, Strep, Chicken Pox, or Shingles? YES NO

Do you or any family member have a history of Malignant Hyperthermia? YES NO

If patient answers "YES" to any of the above questions, the procedure should either be postponed due to infection control issues or the procedure should be performed in the hospital for safety reasons.

YES NO PATIENT HEALTH HISTORY QUESTIONS

☐ ☐ **1. Do you have a history of MRSA?** ***If YES, please have your Physician order two Nose Cultures today that are 48-72 hours apart. Both Cultures must be Negative.***

☐ ☐ **2. Do you have any blood disorders such as Anemia, Leukemia, or Sickle Cell Anemia?**

☐ ☐ **3. Have you ever had any medical problems with your Heart?**

☐ Chest Pain ☐ High Blood Pressure ☐ Irregular Heart Beat/Murmur

☐ Swelling in Hands/Feet ☐ Heart Attack Date: ____

☐ Heart Surgery/Angiogram/Stent/Balloon/Pacemaker/Other (PLEASE CIRCLE)

Date/Procedure:____

Cardiac Testing in last year EKG/Stress Test, etc.____

Cardiologist: ______________________________ Phone Number:______________________________

☐ ☐ **4. Have you ever had any medical problems with your Lungs?**

☐ Asthma Date of last Episode:____________________ ☐ Inhaler ☐ Nebulizer Treatments

☐ Emphysema ☐ Tuberculosis ☐ Sleep Apnea ☐ C-PAP Mask Chronic Cough

☐ ☐ **5. Are you able to climb a flight of stairs without Shortness of Breath?**

☐ ☐ **6. Are you Diabetic? If YES, have you had any "high" or "low" blood sugar reactions in the last (6) months? YES NO (PLEASE CIRCLE)**

EXPLAIN:____

☐ ☐ **7. Do you have any medical problems with your Stomach, Colon, or Liver?**

☐ Reflux/Heartburn ☐ Hepatitis ☐ Jaundice ☐ Crohn's Disease

FOR ENDOSCOPY PATIENTS: Reason you are having this test_______________________________

☐ ☐ **8. Do you have Kidney Failure or are you on Kidney Dialysis? What Days? _____________________**

☐ ☐ **9. Have you ever had a Seizures or Stroke? Date:____**

☐ ☐ **10. Do you have Parkinson's Disease or Multiple Sclerosis?**

☐ ☐ **11. Do you have Chronic Pain (6 months or longer)? Location:_______________________________**

☐ ☐ **12. Do you have a history of Anxiety/Panic or Depression?**

☐ ☐ **13. Do you have any other Medical Problems?____**

Patient Name: ___________________

____

Height _______________ Weight______________ Date of Birth _____________________ BMI____________________

List All Allergies and Reactions: ____

____

YES	NO	
☐	☐	**Do you use Street Drugs? Explain:** ____
☐	☐	**Do you Smoke? If you have quit Smoking, when did you quit?** _________________________
☐	☐	**Do you drink Alcohol? How much?** ____
☐	☐	**Have you ever had Anesthesia or "Twilight" for any procedure?**
☐	☐	**Do you experience nausea/vomiting after surgery?**
☐	☐	**Have you or any family member ever had complications with Anesthesia?** COMMENTS:____
☐	☐	**Do you have any Implanted Devices or Hardware?** ___________________________________
☐	☐	**Have you ever had any Surgical Procedures? Please check all that apply.**

☐ Angioplasty ☐ Appendectomy ☐ Arthroscopy ☐ Back ☐ Bladder ☐ Breast ☐ Cataract/Eye

☐ C-Section ☐ Colonoscopy ☐ D&C ☐ Ear Tubes ☐ Foot Surgery ☐ Gall Bladder ☐ GYNE

☐ Hernia Repair ☐ Hysterectomy ☐ Joint Replacement ☐ Knee ☐ Laparoscopy ☐ Liposuction

☐ Lumpectomy ☐ Lung ☐ Mastectomy ☐ Oral Surgery ☐ Prostate ☐ Sinus Surgery ☐ Shoulder

☐ Tonsils/Adenoids ☐ Thyroid ☐ Tubal Ligation ☐ Upper Endoscopy (EGD) ☐ Wrist/Hand

☐ Other____

FEMALE PATIENTS ONLY: Date of Last Menstrual Period____

Are you Menopausal? If YES, how long? ____

To the best of my knowledge, all medical information is accurate and complete. I realize that withholding information may impact my outcome negatively.

____

SIGNATURE OF PATIENT/GUARDIAN DATE

____

SIGNATURE OF PRE-OP RN/ARSC DATE