Village SurgiCenter

Please provide your medical history by checking the following boxes and answering the questions. Provide any additional information in the space to the right. A nurse will contact you to review the information and discuss your surgery. THANK YOU!

Surgery Date ________________ Surgeon: ____
Reason for procedure: ____

Ride Home: ____

Any travel in past 3 months? _____ Where? ____

Height ________ Weight ________

MEDICAL HISTORY

Cardio: ☐ MI ☐ Hypertension ☐ Angina
☐ SOB or chest pain walking up flight of stairs
☐ Murmur ☐ Prolapse ☐ Premeds Y / N
☐ Arrhythmia ☐ Pacer/Defib- Last ✓ Place?/Date? ______________________________
☐ Hyperlipidemia ☐ Blood vessel disease
☐ Rheumatic Fever ☐ Aneurysm ☐ CAD ☐ CHF
☐ Cardiac Testing? Where/When? ______________________________

Neuro: ☐ Seizures/ Epilepsy Last Seizure?/Type? ______________________________
☐ Fainting ☐ Stroke ☐ TIA ☐ Dementia/Alzheimers ☐ Glaucoma ☐ Migraine HA

Kidney/Bladder/Liver: ☐ Cirrhosis ☐ BPH
☐ Hepatitis Type ________ ☐ Urinary Retention

Respiratory: ☐ Asthma ☐ Emphysema ☐ COPD
☐ Bronchitis ☐ Hay Fever ☐ Environ Allergy
☐ Sleep Apnea CPAP _________ ☐ 0_2 Therapy

Other: ☐ Diabetes- FBS __________ ☐ Thyroid Disease
☐ Hiatal Hernia ☐ GERD/ Ulcers
☐ Immunodeficient ☐ Sickle cell disease ☐ Anemia
☐ Uses assistive device ____________________
☐ Muscle/ Joint Problems ☐ Muscular Dystrophy
☐ Multiple Sclerosis ☐ Arthritis ☐ RLS ☐ Cancer
☐ Mental Health ☐ Anxiety ☐ Depression

Smoke ☐ Current ☐ Hx of ______ packs per day x ______ # years
Alcohol ☐ Yes ☐ No Type/Amount/Frequency: ______________________________
Street Drugs: ☐ Yes ☐ No Type/Amount/Frequency: ______________________________
Any Possibility of Pregnancy? ☐ Yes ☐ No Last Menstrual Period ______________________________
Prosthesis: ☐ Yes ☐ No ______________________________
Jewelry/ Piercings-please identify ______________________________
Dentures/caps/crowns/dental issues: ______________________________
Hearing Aids ____________________ Glasses/ Contacts ____________________

Previous Surgeries/Procedures: ______________________________
____
____
____

☐ Motion Sickness ☐ Post op Nausea/Vomiting
Fever/Reactions to Anesthesia: ☐ Personal ☐ Family
Explain: ____

Pre-Op Testing Ordered: ____
Where and When was it completed: ____

Completed By: ____

PRE-OPERATIVE PHONE CALL ADDENDUM – CMS REGULATIONS

PATIENT NAME: ______________________________

CONTACT DATE: ____________________ **PROCEDURE DATE:** ____________________

Please check the correct answer

LANGUAGE DETERMINATION	**INFORMATION REVIEWED**
Does the patient understand English Yes ☐ No ☐ If no – Language Needed: ____________________	Did you receive the following written information from the physician's office? Rights and Responsibilities Yes ☐ No ☐ Advanced directives Yes ☐ No ☐ Grievance Process contacts Yes ☐ No ☐ Physician Owner disclosure Yes ☐ No ☐
Interpreter Needed: Yes ☐ No ☐ If Yes – Interpreter Contacted Yes ☐ No ☐ Date: ____________________	**IF patient has NOT received above information:** Information will be mailed or emailed to patient . Verify correct mailing address or email address. Notate on the fax schedule. **Information to be mailed** **Yes** ☐ **No** ☐ **Information to be emailed** **Yes** ☐ **No** ☐ **Date mailed/emailed:** ____________________ **Email address:** ____________________ **PLEASE CONTACT US AT 814-836-0770 – WHEN YOU RECEIVE THIS INFORMATION**
VERBAL REVIEW OF INFORMATION **Confirmation of understanding:** **Have you read over the information that you have received. Do you understand your patient rights, information on advanced directives, that you have the right to file a grievance or complaint?** **Yes** ☐ **No** ☐ **Are you aware that Dr. ----- has a financial interest in Village SurgiCenter as a partner?** **Yes** ☐ **No** ☐ **Does the patient or their representative understand this information reviewed** **Yes** ☐ **No** ☐ **If No—Why:** ____________________	**Notes:** ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________

Nurse Signature: ______________________________

Created: 05-18-09

PATIENT MEDICATION SHEET

Patient Name: ______________________________

Information provided by: ☐ Patient/ Family
☐ Medication list from other facility

Do you have a latex allergy? ☐ Yes ☐ No
If yes, what type of reaction ______________________________

Do you have an allergy to tape? ☐ Yes ☐ No
If yes, what type of reaction ______________________________

PLEASE LIST ALL ALLERGIES & REACTIONS TO MEDICATIONS, FOOD OR ENVIRONMENT

DRUG	REACTION

List All Medications Including Over the Counter and Herbal Medications. (Attach additional sheet, if necessary).

Medication Name	Dose	Frequency	To be completed by Pre-Op nurse at time of service

❖❖❖❖❖❖❖❖❖❖To be completed by Village SurgiCenter personnel❖❖❖❖❖❖❖❖❖❖

Patient Signature: ____________________ Nurse Signature: ____________________ Date: __________

Resume All Medications ______________________________

Special Instructions ______________________________

New Medications Upon Discharge	

Patient Signature: ____________________ Nurse Signature: ____________________ Date: __________