PLEASE COMPLETE THIS PRE-PROCEDURE RECORD AND BRING WITH YOU TO YOUR APPOINTMENT.

AMBULATORY SURGERY CENTER

Name:	Age:				
Date of Procedure:Time of Arrival: One hour prior to procedure ti					
Allergies/Reactions:					
Patient informed they are not to drive and a responsible adult should					
accompany them home following discharge from the Surgery Center. Name of driver: Phone Number:					
	Y: (Patient/Family/None)				
Any problems with anesthesia or sedation					
	Nausea/vomiting with general anesthesia				
Slow to wake up with general anesthesia					
Temperature changes					
Comments:					
Do you smoke? NoY	es Amount/day I	Length of time			
Do you drink alcohol? NoYes Amount/day Length of time					
5	No Yes Type				
	nt? YesNo LM				
, 1 0					
HEALTH SURVEY: Plea	ise check if you have expe	rienced any of the following:			
Chest Pain	Pacemaker	Irregular Heart Beat			
High Blood Pressure	Heart Attack	Heart Murmur			
Heart Surgery	Shortness of Breath	Emphysema			
Asthma	Bronchitis	Persistent Cough			
Pneumonia	Tuberculosis	High Fevers			
Seizures	Stroke	Headaches			
Arthritis	Thyroid Problems	Pins/Plates			
Liver Disease	Hepatitis	Jaundice			
Anemia	Bleeding/bruising	Diabetes			
Kidney Disease	Bladder Problems	Stomach Problems			
Anxiety	Depression	Bowel/Colon Problems			
Comments:		· —			

Name	Dose	Frequency	Last Dose
Previous Surgery:			
Type		Date	
Comments:			
Patient/Guardian Signa	ture		Date

PREPROCEDURE RECORD 4/00