DARTMOUTH-HITCHCOCK • MANCHESTER

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 time**
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: _____

ANESTHESIA HISTORY: (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? No __ Yes __ Amount/day_____ Length of time_____
Do you drink alcohol? No __ Yes __ Amount/day ____ Length of time _____
Do you use street drugs? No __ Yes __ Type _____
Women: Are you pregnant? Yes___ No___ LMP: _____

HEALTH SURVEY: Please check if you have experienced 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: _____
_____
_____
_____

Current Medications:

Name	Dose	Frequency	Last Dose

Previous Surgery:

Type	Date

Comments: _____
_____
_____
_____
_____

Patient/Guardian Signature _____Date_____