Lutherville SurgiCenter, LLC

HEALTH SURVEY

TO BE COMPLETED BY PATIENT

Please complete and return to the Center no later than two days prior to your date of surgery. This information is important for us to review before we call you with your pre-operative instructions.

Name _____ Date Survey Completed _____ Surgical Procedure and Date of Surgery _____

Street Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell# _____ DOB _____

Height _____ Weight_____ Are you allergic to latex/rubber products? YES○ NO○

Are you allergic to any medications? YES○ NO○ Please list: _____

Are you allergic to any foods? YES○ NO○ Please list: _____

List all medical illnesses _____

List previous surgeries and date _____

	YES	NO	EXPLANATION
Have you ever had a problem with anesthesia?	○	○	_____
Has anyone related to you ever had a problem with anesthesia?	○	○	_____
Are you nursing?	○	○	
Could you be pregnant?	○	○	Date of last period _____
Do you smoke?	○	○	# packs _____ #years _____
Do you have asthma?	○	○	_____
Have you had any difficulty with breathing?	○	○	_____
Do you have mitral valve prolapse?	○	○	_____
Do you have high blood pressure?	○	○	_____
Have you ever had angina or pain in the chest?	○	○	_____
Have your ever had a stroke?	○	○	_____
Do you have a hiatal hernia/GERD?	○	○	_____
Are you diabetic?	○	○	_____
Have you ever had epilepsy, seizures, or fainting spells?	○	○	_____
Have you ever had hepatitis?	○	○	_____
Do you have a pacemaker/AICD?	○	○	_____
Do you have any physical limitations?	○	○	_____
Do you wear glasses, contact lens?	○	○	_____
Do you have impaired hearing? Hearing aid?	○	○	_____
Do you drink alcohol?	○	○	Amount: _____
Have you ever or do you take illegal drugs?	○	○	_____

Please list **ALL** your current medications with does and frequency. Also include any over the counter medicines, vitamins, herbal and/or natural medications you may be taking.

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

Pharmacy Name/Phone Number: _____

Medications reviewed by: Pre-op Nurse _____

Discharge Nurse _____

If you are to receive general anesthesia or sedation, you **MUST have someone to drive you home. We also strongly suggest you have someone stay with you for the first 24 hours. If you **DO NOT** have someone to drive or escort you home, your surgery will be **canceled** and rescheduled for when you have someone available.

Name of person who will be taking you home:_____

Comments: _____

_____

_____

_____

_____

_____

_____