PREOPERATIVE CONTACT NUMBERS

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Other Contact Person & Phone: _____

MEDICAL HISTORY:
(√) See Preoperative Admission Form

MEDICATION RECONCILLIATION:
(√) See Medication Reconciliation Form
( ) NOT ANY TAKING MEDICATIONS AT THIS TIME

GENERAL PREOPERATIVE INSTRUCTIONS:
(__) **NPO after** _____on _____ **Clear Liquids until** _____ **on** _____
(__) Told to take **ALL** medications: **Except blood thinners, aspirin, and AM insulin.**
(__) Told to bring a list of current medications or medications themselves.
(__) Name spelled correctly? ☐ Yes ☐ No – Correction _____.
(__) Blood tests, X-rays or ECG performed recently? ☐ Yes ☐ No ☐ N/A
(__) KASC address and directions given? ☐ Yes ☐ No.
(__) Bring insurance card(s) and most current photo ID.
(__) Wear loose comfortable clothing.
(__) **MUST HAVE ADULT TO DRIVE YOU HOME FROM CENTER OR CASE WILL BE CANCELLED.**
(__) Phone numbers for person driving you home after your procedure.
(__) Estimated length of stay will be _____.
(__) Who will help you at home? _____.
(__) Do not bring valuables. No cash or credit cards, **earrings, rings, necklaces, or body piercings**.
(__) _____.

ATTEMPTS TO CONTACT PATIENT:
Date: _____Time: _____ Nurse: _____
( ) Left Message ( ) Non-Working Number/Unable to leave message
( ) Spoke to: Patient/Family (name and relationship): _____
( ) Preoperative instructions given. Patient stated understanding. Medical history and medication list reviewed
Comment(s): _____

Date: _____ Time: _____ Nurse: _____
( ) Left Message ( ) Non-Working Number/Unable to leave message
( ) Spoke to: Patient/Family (name and relationship): _____
( ) Preoperative instructions given. Patient stated understanding. Medical history and medication list reviewed
Comment(s): _____

Date: _____ Time: _____ Nurse: _____
( ) Left Message ( ) Non-Working Number/Unable to leave message
( ) Spoke to: Patient/Family (name and relationship): _____
( ) Preoperative instructions given. Patient stated understanding. Medical history and medication list reviewed
Comment(s): _____

ADVANCED SURGICAL CENTER

PREOP PATIENT CALL RECORD

Patient Label

LANGUAGE SPOKEN: _____ **SPECIAL: HOH/BLIND OTHER:** _____

ALLERGIES TO FOOD AND/OR MEDICATIONS: ☐ **None** ☐ **Yes** **Gender:** ☐ Male ☐ Female ☐ Other

Allergies To: _____

Reaction(s): _____

Please check and/or circle all applicable boxes:

GENERAL ☐ History of anesthesia issues **What happened:** _____
☐ Motion sickness/vertigo/dizziness ☐ Tinnitus ☐ HOH ☐ Hearing aids
☐ Corrective eye surgery **Y/N Type:** _____
☐ Glasses (read only/corrective)/contact lenses/blind
☐ Loose teeth/caps/bridges/partial/No Teeth ☐ Dentures: Upper/Lower/Both
☐ Unexplained Weight Loss>10% ☐ Night sweats/chills
☐ Skin Issues: **Y/N Type:** _____ ☐ **NONE OF THE ABOVE**

****

RESPIRATORY
☐ Asthma
☐ Bronchitis
☐ COPD
☐ Valley Fever
☐ "Hay Fever"
☐ Respiratory Infection
☐ Productive Cough
☐ Pneumonia
☐ TB
☐ Sleep Apnea ☐ C-Pap ☐ Bi-Pap ☐ N/A ☐ Supplemental 02 ☐ Liters: _____
☐ Seasonal allergies ☐ TMD/TMJD ☐ **NONE OF THE ABOVE**

****

CARDIOVASCULAR
☐ Hypertension/Hypotension
☐ Abnormal ECG
☐ Congestive Heart Failure
☐ Heart Attack
☐ Pacemaker
☐ Hyperlipidemia
☐ Irregular Heartbeat
☐ Heart Murmur
☐ CVA/TIA/Stroke
☐ Leg swelling **L/R/Both**
☐ Bruises easily
☐ Varicose veins
☐ Angioplasty ☐ W/Stents ☐ W/O ☐ Stent Placement@: _____
☐ Cardiomegaly
☐ Coronary Artery Disease
☐ Bleeding Disorder/Anemia
☐ Cardiomyopathy
☐ Peripheral Vascular Disease
☐ Blood Clots: DVT/PE
☐ History of: Rheumatic Fever/Heart defect/endocarditis ☐ **NONE OF THE ABOVE**

****

HEPATO/GASTROINTESTINAL ☐ "Stomach issues" _____
☐ Difficulty Swallowing
☐ Cirrhosis
☐ GERD/Heart Burn
☐ Chronic Constipation
☐ Hernia: Hiatal/Inguinal/Umbilical ☐ Repaired **Y/N**
☐ Intestinal Issues **Type:** _____
☐ Hepatitis: **A/B/C** ☐ Treated **Y/N**
☐ Enlarged/Fatty Liver/"Liver issues"
☐ Peptic Ulcer Disease
☐ Bariatric Surgery
☐ **NONE OF THE ABOVE**

****

NEURO/MUSCULOSKELATAL ☐ Osteoporosis/Osteopenia
☐ Paralysis
☐ Neuropathy
☐ Muscle Weakness/Cramps
☐ Arthritis/Osteo/DJD/DDD
☐ Gout
☐ Frequent falls/Unsteady gait
☐ Neuromuscular Disease
☐ Seizures ☐ **Last SZ:** _____ ☐ Unknown
☐ Headaches/Migraines
☐ Scoliosis/Kyphosis/Lordosis
☐ History of shingles/Bell's Palsy
☐ History of Fractures
☐ Ambulates with: ☐ Cane ☐ Crutches ☐ FWW ☐ W/C ☐ **NONE OF THE ABOVE**

****

RENAL/ENDOCRINE ☐ "Kidney issues" _____
☐ Thyroid Dysfunction
☐ Diabetes **Pre/ I/II**
☐ Frequent UTI's/Kidney Infections
☐ Urinary Dysfunction ☐ Incontinence ☐ OAB ☐ Urgency ☐ Frequency
☐ Very little/no urine
☐ Renal Disease/Failure/Insufficiency
☐ Kidney Stones
☐ Enlarged prostate
☐ **NONE OF THE ABOVE**

IMMUNE SYSTEM
☐ Immunodeficiency **Type:** _____
☐ Autoimmune disorder **Type:** _____
☐ Cancer/Leukemia **If so, type/location:** _____
☐ Radiation Therapy **Last TX:** _____
☐ Chemotherapy **Last TX:** _____
☐ **NONE OF THE ABOVE**

****

PSYCHO/SOCIAL
☐ Smoker **Type: vape/cigarettes** _____/packs **Per: Day/Week Quit:** Y/N
☐ Alcohol Use (**Occasionally/Moderately/Daily) Type:** _____ **Quit:** Y/N
☐ Illicit Drug Use **Type:** _____ **Frequency:** _____ **Quit:** Y/N _____
☐ Bipolar Disorder
☐ Anxiety
☐ Other Psychiatric D/O: _____
☐ Sleep dysfunction
☐ Depression
☐ Suicidal Ideations
☐ **NONE OF THE ABOVE**

WOMEN
Pregnant/Nursing: ☐ **Yes** ☐ **No** ☐ **N/A**
Artificial Nails/Paint: ☐ **Yes** ☐ **No**

****

SURGICAL HISTORY (Implants, etc.) ☐ **NONE**
Surgery(ies) and dates (Specify):

Pre-Op Call Nurse: _____
Date: _____

Patient Signature: _____
Date: _____

****

SCHEDULED PROCEDURE/SURGERY:

****

ANESTHESIA: ☐ **N/A** ☐ **General** ☐ **Moderate Sedation**
☐ **MAC** ☐ **Local** ☐ **Conscious Sedation**

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PREOPERATIAVE ADMISSION FORM

Patient Label

Reviewed/revised 05/2020