PLEASE FILL OUT COMPLETELY, DETACH AND BRING WITH YOU ON THE DAY OF YOUR PROCEDURE.

Name: _____ Height: _____ Weight: _____

PLEASE COMPLETE BEFORE YOU COME IN FOR YOUR SURGERY/PROCEDURE
PLEASE REMEMBER TO BRING WITH YOU ON THE DAY OF YOUR SURGERY/PROCEDURE

❑ NO KNOWN ALLERGIES

ALLERGIES/SENSITIVITIES TO: (Food, Dietary Supplements, Medications including prescriptions and over-the-counter, environmentals, rubber/latex, or other materials. Please describe type of reaction to each.)

_____
_____
_____
_____
_____
_____
_____

LIST SURGERIES: _____
_____
_____
_____
_____
_____

Barriers:
❑ Hard of Hearing (Aides: R/L/Both)
❑ Blind (R/L/Both)
❑ Foreign Language/Interpreter
❑ Diminished Mental Status
❑ Wheelchair
❑ Cane

Any possibility that you are pregnant?
❑ Yes ❑ No

Date of last menstrual period _____ ❑ N/A

PLEASE CHECK (✓) IF YOU HAVE A HISTORY OR CURRENTLY HAVE ANY OF THESE CONDITIONS:

❑ High Blood Pressure
❑ Heart Attack
❑ Heart/Chest Pains
❑ Congestive Heart Failure
❑ Heart Bypass Surgery
❑ Heart Valve Replacement
❑ Pacemaker/Internal Defibrillator
❑ Heart Cath/Stent/Angioplasty
❑ Rheumatic Fever
❑ Irregular Heart Rhythm
❑ Valve Disease or Heart Murmur
❑ Smoker - How many packs a day?_____ Quit date?_____
❑ Asthma
❑ Emphysema
❑ Bronchitis
❑ Pneumonia
❑ Difficulty Breathing
❑ Cancer
❑ Kidney Problems
❑ Dialysis
❑ Kidney Stones
❑ Problems Urinating
❑ Liver Problems
❑ Hepatitis
❑ Alcohol Use - How much each day? _____
❑ Glaucoma
❑ Problems Moving Neck/Jaw
❑ Stroke/TIA
❑ Seizures
❑ Myasthenia Gravis
❑ Mental Health Problems
❑ Ulcers
❑ Hiatal Hernia
❑ Heartburn/Acid Reflux
❑ Difficulty Swallowing
❑ Nausea, vomiting, abdominal pain
❑ Constipation or diarrhea
❑ Anemia
❑ Blood Disorders/Bleeds Easily
❑ Clotting Problems
❑ High Cholesterol
❑ Diabetes
❑ Thyroid Problems
❑ Artificial Joints or Metal Implants
❑ Arthritis
❑ Artificial Eyes
❑ Limbs
❑ Eyeglasses/contact lens
❑ Dentures/Partials
❑ Other

GATEWAY SURGERY CENTER

Please continue on back page.

MEDICATIONS: Please list all prescription, over-the-counter, herbal, and dietary supplements.

❑ If attaching a list of medications, please include last dose taken.

MEDICINE	DOSAGE	FREQUENCY	LAST DOSE TAKEN

Patient Signature: _____ Date: _____

RN Signature: _____ Date: _____

Who's driving you home today?

Name: _____

Relationship: _____

Phone: _____

Cell: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone: _____

Cell: _____

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