[redacted]
Spartan Health Surgicenter
100 Stoops Drive
Monongahela, Pa 15063
[redacted]

Place Patient Info Label Here

NURSING PRE-OPERATIVE ASSESSMENT

Please complete this questionnaire as accurately as possible to provide information about your health history. Bring this form with you on the day of your procedure. It will be reviewed by members of the nursing and anesthesia staff.

IF YOU ARE TO RECEIVE GENERAL ANESTHESIA OR SEDATIVE MEDICATIONS, YOU MUST HAVE A RESPONSIBLE ADULT TO DRIVE YOU FROM THE SURGERY CENTER AND TO BE AVAILABLE TO HELP DURING THE FIRST DAY.

Medical History: Please check if any of these problems have ever applied to you:

__ Breathing Problems
__ Heart Problems / Chest Pain
__ High Blood Pressure
__ Strokes / Seizures / Fainting
__ Frequent Headaches
__ Blurred Vision
__ Liver Disease / Jaundice
__ Stomach / Bowels / Ulcers
__ Kidney / Urinary / Prostate
__ Sleep Apnea / Snoring
__ Gynecological Problems
__ Special Communication Needs – List _____

__ Muscular / Numbness / Tingling
__ Bone Disease/Broken Bones/Arthritis
__ Thyroid Disorders
__ Mental Disorders
__ Blood Disorders
__ Cancer Type: _____
__ Diabetes
__ Tobacco Use/Substance Abuse
__ Anesthesia Complications
__ Physical Disabilities
__ Back Problems / Osteoporosis

__ History of active or recently diagnosed tuberculosis
__ Unexplained weight loss beyond normal fluctuation
__ Loss of appetite for more than 2 months
__ Fatigue that interferes with daily activities
__ Persistent temperature elevations
__ Sweating that leaves bedclothes moist
__ Aids / HIV Positive
__ Chronic Pain
Are you receiving: __ Steroids __ Chemotherapy
__ Eye-ear-nose and throat
__ Problems with ingestion, digestion or food absorption
__ MRSA
Other Explain: _____

__ Are You Being Abused, Neglected or Abandon by Anyone: Explain_____

Allergies, reactions, intolerances to any medications, food or other substances / LATEX – NO YES – Explain_____

Height: _____ Weight: _____ BMI:_____ **PERSON WHO WILL BE TAKING YOU HOME_____**

Surgical History: Have you had any previous surgery? __ Yes __ No Please list surgeries and years performed:_____

Have your or any of your immediate family had any problems with anesthesia? __ Yes __ No Explain:_____

Have you had any of these within the past week? (circle if yes) Cough Cold Sore Throat Hoarseness Fever

For female patients: Do you think you could be pregnant? __ Yes __ No Last Menstrual Period _____

Medications Taken Regularly (List ALL including non-prescription, vitamins and herbal components)

Medication Name & Dose	Frequency Taken	Medication Name & Dose	Frequency Taken

Reviewed by: _____, R.N. Date: _____

Has there been any change the patient's health or medications since their last visit here?

2nd Visit: __ Yes __ No Explain :_____Reviewed by:_____ Date:_____
3rd Visit: __ Yes __ No Explain: _____ Reviewed by :_____Date:_____
4th Visit: __ Yes __ No Explain: _____ Reviewed by: _____Date:_____

Diagnosis and Procedure Summary List (to be completed by RN, CRNA or Doctor/Dentist on 3rd visit)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Reviewed by: _____ R.N./M.D. Date: _____
Reviewed by: _____ R.N./M.D. Date: _____
Reviewed by: _____ R.N./M.D. Date: _____