Gulf South Surgery Center Pre-Operative Evaluation

Patient Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Physician: _____ Procedure: _____ Date of Surgery: _____

Please List Your Medications, Including Non-Prescription:

_____

◯ Y ◯ N 1. Have you ever had surgery before? If yes, please list them. _____

_____

◯ Y ◯ N 2. Is there any patient or family history of anesthesia complications?

◯ Y ◯ N Have you ever experienced nausea or vomiting after surgery? If yes, please explain.

_____

◯ Y ◯ N 3. Are you allergic to any drugs? If yes, please list them.

_____

◯ Y ◯ N 4. Do you have a food or latex allergy? If yes, please explain. _____

_____

◯ Y ◯ N 5. Do you have Heart Disease, Heart Surgery, Stents? _____

◯ Y ◯ N 6. Have you ever had a Heart Attack? If yes, when? _____

◯ Y ◯ N 7. Do you have High Blood Pressure? _____

◯ Y ◯ N 8. Do you have a Seizure Disorder? _____

◯ Y ◯ N 9. Have you ever had a Stroke or TIA? _____

◯ Y ◯ N 10. Do you have any of the following? Check all that apply

- ☐ Psychiatric Disorders
- ☐ Anxiety
- ☐ Depression
- ☐ ADD
- ☐ ADHD
- ☐ None

◯ Y ◯ N 11. Do you have Lung Disease? _____

◯ Y ◯ N 12. Do you have Sleep Apnea? _____ CPAP or BIPAP machine _____

◯ Y ◯ N 13. Have you recently had a cough or cold? _____

◯ Y ◯ N 14. Do you have any Gastro Intestinal problems (ie. Reflux, Ulcers)? _____

◯ Y ◯ N 15. Do you have Thyroid Disease? _____

◯Y ◯N 16. Do you have Diabetes or Hypoglycemia? (None)

◯Y ◯N Do you take insulin?

Type: _____

◯Y ◯N 17. Have you ever had Hepatitis or Liver Disease?

◯Y ◯N 18. Do you have Full Range of Motion in your neck? Please explain any limitations. _____

_____

◯Y ◯N 19. Do you have any Muscle or Bone problems? _____

_____

◯Y ◯N 20. Do you have any Bladder or Kidney Disease? _____

◯Y ◯N 21. Do you have a history of Anemia? _____

◯Y ◯N 22. Do you have any bleeding disorders? _____

◯Y ◯N 23. Do you have any infectious diseases, such as HIV/AIDS? _____

◯Y ◯N 24. Have you had a Hysterectomy or Tubal Ligation? If yes please check all that apply:

☐ Hysterectomy

☐ Tubal Ligation

◯Y ◯N 25. Any possibility you could be pregnant? If yes, you will need to be tested. _____

◯Y ◯N 26. Please describe your activity level. (Exercise regularly? Need assistance walking?)

_____

◯Y ◯N 27. Do you have any loose, chipped, or false teeth? Any dental work in your front teeth (caps, crowns, veneers)?

◯Y ◯N 28. Do you wear contact lenses? If yes, please remove them prior to surgery. _____

◯Y ◯N 29. Do you drink alcohol? If yes, do you drink socially, weekly, or daily? (none)

◯Y ◯N 30. Do you smoke tobacco? If yes, how many per day? _____

◯Y ◯N Do you have any Advanced Directives? _____

Family History (Parents and Siblings Only)

Heart Condition?	◯Y ◯N	History of sickle cell trait?	◯Y ◯N
High blood pressure?	◯Y ◯N	Bleeding problem?	◯Y ◯N
Recent cold/flu?	◯Y ◯N	History of seizure disorder?	◯Y ◯N
Diabetes?	◯Y ◯N	Muscle or nerve disease?	◯Y ◯N
History of MRSA?	◯Y ◯N	Difficulties with anesthesia?	◯Y ◯N

*Lab Work or an EKG may be required prior to surgery based on your medical history. If your surgeon has already ordered these, please fill in the following:

EKG ☐ Where _____ Date _____

Lab ☐ Where _____ Date _____

Medical/Cardiac Clearance ☐ Physician _____

Completed by:

Name: _____

Relationship to Patient: _____

Phone: | | | | | | | | | | |

Contact Information:

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Print Form