

VALLEY AMBULATORY SURGERY CENTER

ST CHARLES, IL

630-584-9800 - FAX 630-584-9902

PATIENT HISTORY FORM

PATIENT NAME:		SURGEON:		DATE OF PROCEDURE:			
				Y	N		
HEIGHT:	WEIGHT:	A cold in past 2 weeks				Do you drink alcohol?	
		Shortness of breath/resp. difficulty				Do you use recreational drugs?	
HAVE YOU HAD ANY OF THE FOLLOWING:		Y	N	Asthma		You or your family have a history of bleeding problems?	
Recent (<1 month) Major Surgery				Pneumonia		Back Injury	
Inflammatory Bowel Disease				Tuberculosis		Convulsions, epilepsy	
Varicose Veins				Any other lung disease?		Polio, paralysis, meningitis	
Do you smoke?				Diabetes		Arthritis	
Emphysema or COPD				Kidney Trouble		Tubal ligation	
Birth Control Pill/Patch/Implant/Shot				Anemia		Dentures, partials, loose teeth	
Hormone Replacement Therapy				Acid reflux		Sleep Apnea	
Been Pregnant in last 6 mo				Jaundice, hepatitis, liver problems		You or your family have a history of Malignant Hyperthermia?	
Cancer or Malignancy Presently				Thyroid trouble		Have you or your family had an unusual reaction to anesthesia?	
Central IV Line or Port				High Blood Pressure		Any other medical conditions? (list)	
You or Family ever have: Blood Clot(s)				Chest pain, Angina			
" ": Pulmonary Embolus				Heart Attack(s)			
" ": Blood Clotting Disorder				Fast or irregular heart beat			
Congestive Heart Failure				Heart murmur, mitral valve prolapse			
Stroke				Rheumatic Fever			
				Any other Heart Problems? (list)		Any Previous Surgeries? (list)	
Have you had Steroid Meds in last 6 mo.?							
LATEX ALLERGY				Any other allergies?			
MEDICATION ALLERGIES? (please list drug and reaction it caused)							
						LAST EKG: (when and where):	
Please list all CURRENT MEDICATIONS: (include all prescription drugs and over the counter and herbal remedies)							
MEDICATION:		DOSAGE		TIME OF DAY USUALLY TAKEN		LAST DOSE (office use only)	
PRIMARY DOCTOR NAME/PHONE NUMBER:		NURSES NOTES/COMMENTS					
REVIEWED WITH PATIENT		RN		DATE:			
DO YOU HAVE ADVANCE DIRECTIVES/LIVING WILL?		Y	N				
I HAVE RECEIVED THE SPECIAL PATIENT INFORMATION/BILL OF RIGHTS BEFORE THE DAY OF SURGERY		Y	N				
PATIENT/GUARDIAN SIGNATURE:		DATE:					

PLEASE FILL IN ENTIRE FORM, SIGN, AND FAX TO 630-584-9902 (or return in the enclosed envelope) AND BRING ORIGINAL WITH YOU THE DAY OF SURGERY