VALLEY AMBULATORY SURGERY CENTER

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ST CHARLES, IL
630-584-9800 FAX 630-584-9902

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PATIENT HISTORY FORM

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PATIENT NAME:	SURGEON:	DATE OF PROCEDURE:

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		
Recent (<1 month) Major Surgery			Pneumonia			of bleeding problems?		
Inflammatory Bowel Disease			Tuberculosis			Back Injury		
Varicose Veins			Any other lung disease?			Convulsions, epilepsy		
Do you smoke?			Diabetes			Polio, paralysis, meningitis		
Emphysema or COPD			Kidney Trouble			Arthritis		
Birth Control Pill/Patch/Implant/Shot			Anemia			Tubal ligation		
Hormone Replacement Therapy			Acid reflux			Dentures, partials, loose teeth		
Been Pregnant in last 6 mo			Jaundice, hepatitis, liver problems			Sleep Apnea		
Cancer or Malignancy Presently			Thyroid trouble			You or your family have a history		
Central IV Line or Port			High Blood Pressure			of Malignant Hyperthermia?		
You or Family ever have: Blood Clot(s)			Chest pain, Angina			Have you or your family had an		
" ": Pulmonary Embolus			Heart Attack(s)			unusual reaction to anesthesia?		
" ": Blood Clotting Disorder			Fast or irregular heart beat			Any other medical conditions? (list)		
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

3/11

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