

# CENTRAL PARK SURGERY CENTER

Patient Name  Preferred Name   
 Day Phone  Cell Phone  Evening Phone   
 Height  feet  inches Weight  Sex M F Date of Birth

PATIENT DEMOGRAPHICS

Your Name  Phone Number   
 Relationship to Patient

Procedure Date  Procedure Time   
 Name of Surgeon   
 Description of Procedure

\* If you are a legal guardian, have power of attorney or advanced directives (living will), please bring documentation.

Emergency Contact  Phone Number   
 Name of Person driving patient home from surgery   
 Name of Person caring for patient after surgery

LABWORK

Has the patient had any of the following in preparation for surgery? If YES, please include date/location.

Have you had an EKG done in preparation?	YES	NO	Where <input type="text"/>	When <input type="text"/>
Have you had any X-rays in preparation?	YES	NO	Where <input type="text"/>	When <input type="text"/>
Have you had any blood tests in preparation?	YES	NO	Where <input type="text"/>	When <input type="text"/>
Have you had any other preparation?	YES	NO	Where <input type="text"/>	When <input type="text"/>

ALLERGIES

**CLICK HERE IF YOU HAVE NO KNOWN ALLERGIES. THEN PROCEED TO THE DIABETES SECTION.**

ALLERGIES	YES	NO	Comments/Explanation
Drug allergies? List: <input type="text"/>			<input type="text"/>
Food allergies? List: <input type="text"/>			
Latex/rubber allergies?			
Other allergies? List: <input type="text"/>			
Other abnormal drug reactions? Explain at right.			

DIABETES

**CLICK HERE IF YOU ARE NOT DIABETIC. THEN PROCEED TO THE ANESTHESIA SECTION.**

Are you diabetic?   
 Is your diabetes diet controlled?   
 Do you use:   Injectable insulin   Oral medications   Insulin pump  
 Do you have hypoglycemia?   
 Do you check your blood sugar daily? How often?

**ANESTHESIA**

**CLICK HERE IF YOU HAVE NO ANESTHESIA CONCERN. THEN PROCEED TO THE SURGICAL HISTORY SECTION.**

Have you had an unusual reaction to anesthesia such as high temperature, difficulty waking up, nausea and/or vomiting, or breathing difficulties?

Has any blood relative had any unusual reactions like high fever or prolonged weakness?

**SURGICAL HISTORY**

**CLICK HERE IF YOU HAVE NO SURGICAL HISTORY. THEN PROCEED TO THE MEDICATIONS SECTION.**

**Surgical History**

Procedure	<input type="text"/>	Date	<input type="text"/>
Procedure	<input type="text"/>	Date	<input type="text"/>
Procedure	<input type="text"/>	Date	<input type="text"/>
Procedure	<input type="text"/>	Date	<input type="text"/>

Do you have any implants or prostheses?

YES NO

Type	<input type="text"/>	Location	<input type="text"/>	Date	<input type="text"/>
Type	<input type="text"/>	Location	<input type="text"/>	Date	<input type="text"/>

**MEDICATIONS**

**CLICK HERE IF YOU ARE TAKING NO MEDICATIONS. THEN PROCEED TO THE DOCTORS SECTION.**

Are you currently taking any medications? (herbal, prescribed, over-the-counter, steroids, diet pills, other)

If YES, please include name/dosage/how often

Type	<input type="text"/>	Dosage	<input type="text"/>	How often	<input type="text"/>
Type	<input type="text"/>	Dosage	<input type="text"/>	How often	<input type="text"/>
Type	<input type="text"/>	Dosage	<input type="text"/>	How often	<input type="text"/>
Type	<input type="text"/>	Dosage	<input type="text"/>	How often	<input type="text"/>
Type	<input type="text"/>	Dosage	<input type="text"/>	How often	<input type="text"/>
Type	<input type="text"/>	Dosage	<input type="text"/>	How often	<input type="text"/>
Type	<input type="text"/>	Dosage	<input type="text"/>	How often	<input type="text"/>
Type	<input type="text"/>	Dosage	<input type="text"/>	How often	<input type="text"/>
Type	<input type="text"/>	Dosage	<input type="text"/>	How often	<input type="text"/>

Did your doctor instruct you to -stop- taking any medications in preparation for surgery?

If YES, please include name/dosage/last taken

Type	<input type="text"/>	Dosage	<input type="text"/>	Last taken	<input type="text"/>
Type	<input type="text"/>	Dosage	<input type="text"/>	Last taken	<input type="text"/>
Type	<input type="text"/>	Dosage	<input type="text"/>	Last taken	<input type="text"/>
Type	<input type="text"/>	Dosage	<input type="text"/>	Last taken	<input type="text"/>

Did your doctor instruct you to -take- any medications before coming to surgery?

If YES, please include name/dosage/time taken

Type  Dosage  Time taken

DOCTORS

Please list physicians who care for you on a regular basis and/or during the past year (include primary care).

Physician  Specialty  Phone

Physician  Specialty  Phone

Physician  Specialty  Phone

Physician  Specialty  Phone

CLICK HERE IF YOU HAVE NO IMPAIRMENTS. THEN PROCEED TO THE DENTAL SECTION.

IMPAIRMENTS

Question	YES	NO	Comments/Explanation
Do you have hearing impairments?			<input type="text"/>
Vision impairments? Glasses or contacts?			
Mobility impairments?			
Artificial limbs?			
Other impairments or disabilities?			

CLICK HERE IF YOU HAVE NO DENTAL ISSUES. THEN PROCEED TO THE SKIN SECTION

DENTAL

Do you have dentures or bridges?		<input type="text"/>
Caps or crowns?		
Chipped or loose teeth?		
Do you wear any retainers?		

CLICK HERE IF YOU HAVE NO SKIN CONDITIONS. THEN PROCEED TO THE STOMACH SECTION.

SKIN

Do you have any burns?		<input type="text"/>
Rashes?		
Bruises?		
Other skin conditions?		
Does your skin tear easily?		

CLICK HERE IF YOU HAVE NO STOMACH CONDITIONS. THEN PROCEED TO THE PSYCHIATRIC SECTION.

STOMACH

Do you have ulcers or hiatal hernia?		<input type="text"/>
Acid reflux disease?		
Gallbladder conditions?		
GI/rectal bleeding?		

**CLICK HERE IF NO PSYCHIATRIC CONDITIONS. THEN PROCEED TO THE NEUROLOGICAL SECTION.**

**PSYCHIATRIC**

Have you ever been treated for depression?

Anxiety or panic disorder?

Substance abuse?

Developmental delays?

Other psychiatric conditions?

**CLICK HERE IF NO NEUROLOGICAL CONDITIONS. THEN PROCEED TO THE MUSCULO-SKELETAL SECTION.**

**NEUROLOGICAL**

Have you ever had a stroke or TIA? (list dates)

Have you ever had any seizures?

Do you suffer from any paralysis? (explain)

Do you have Alzheimers?

Parkinsons?

Other neurological conditions? (explain?)

**CLICK HERE IF NO MUSCULO-SKELETAL CONDITIONS. THEN PROCEED TO THE HEMATOLOGICAL SECTION.**

**MUSCULO-SKELETAL**

Do you have any neck, back, or jaw problems?

Joint replacement or dislocation?

Muscular dystrophy?

Arthritis?

Other musculoskeletal conditions? (explain)

**CLICK HERE IF YOU NO HEMATOLOGICAL CONDITIONS. THEN PROCEED TO THE LIVER SECTION.**

**HEMATOLOGICAL**

Have you ever had blood transfusions?

Blood clots?

Do you have sickle cell disease?

Anemia?

Other blood conditions? (explain)

Do you bruise easily?

Are you taking any blood thinners?

Are you taking aspirin or ibuprofen?

Are you taking Vitamin E?

Does your family have a history of hemophilia?

**CLICK HERE IF YOU HAVE NO LIVER CONDITIONS. THEN PROCEED TO THE THYROID SECTION.**

**LIVER**

Do you have jaundice?

Cirrhosis?

Hepatitis? (list type)

THYROID

CLICK HERE IF YOU HAVE NO THYROID CONDITIONS. THEN PROCEED TO THE KIDNEY SECTION.

Do you have hypothyroidism?

Hyperthyroidism?

Other thyroid conditions?

KIDNEY

CLICK HERE IF YOU HAVE NO KIDNEY CONDITIONS. THEN PROCEED TO THE PAIN SECTION.

Burning when urinating? (List frequency)

Bleeding when urinating? (List frequency)

Are you on dialysis?

Other urinary problems?

PAIN

CLICK HERE IF YOU HAVE NO PAIN ISSUES. THEN PROCEED TO THE CARDIOVASCULAR SECTION.

(0) No Pain (1-2) Hurts a little (3-4) Hurts a little more (5-6) Hurts even more (7-8) Hurts a whole lot (9-10) Hurts the worst

Do you have chronic pain?

YES NO

Location

Pain scale (0-10)

How long

Do you currently have pain associated with the condition for which you are having the procedure?

YES NO

Location

Pain scale (0-10)

CARDIOVASCULAR

CLICK HERE IF NO CARDIOVASCULAR ISSUES. THEN PROCEED TO THE PULMONARY SECTION.

Question YES NO

Comments/Explanation

Do you have or have you ever had angina/chest pain?

High blood pressure?

Low blood pressure?

Rheumatic fever?

Congestive heart failure?

Mitral valve prolapse?

Heart surgery/stent/catheter?

Date(s)

Heart attack?

Date(s)

Palpitations or an irregular heartbeat?

Do you use a pacemaker/defibrillator?

Date(s)

Manufacturer

**CLICK HERE IF NO PULMONARY ISSUES. THEN PROCEED TO THE "OTHER" SECTION.**

**PULMONARY**

Do you have asthma?

Restrictive airway disease (RAD)?

Bronchitis/COPD?

Sleep apnea? If YES, do you use CPAP?

Do you have or have you ever been exposed to TB?

Do you use a Nebulizer or Home Breathing Machine?

Do you ever have shortness of breath?

Do you smoke/use tobacco? (How much?) Packs per day  Years

Are you using oxygen at home?

Have you had a cold in the past 2 weeks?

Do you have any other pulmonary conditions?

**CLICK HERE IF NOTHING IN THE "OTHER" SECTION APPLIES. THEN PROCEED TO THE WOMEN SECTION.**

**OTHER**

Do you drink alcohol?

Do you use recreational drugs?

Do you have any body piercings?

Do you have any contagious diseases?

Do you have or have you ever had cancer?

Patient's primary language? English Spanish Other

YES NO

Will the patient need an interpreter?

Will the patient bring an interpreter? Name

Has the patient been to this center before? Date

Are there any spiritual/cultural needs? (Explain)

**WOMEN**

**CLICK HERE IF YOU ARE NOT A WOMAN. THEN PROCEED TO THE MINORS SECTION.**

When was your last menstrual period? Date

Are you pregnant or trying to get pregnant?

**MINORS**

**CLICK HERE IF PATIENT IS NOT A MINOR. THEN PROCEED TO COMMENTS SECTION BELOW OR SUBMIT.**

Was the patient born pre-mature?

Are the patient's immunizations up to date?

Does anyone in your household smoke or use tobacco?

Please list any special needs or concerns.



Additional comments.

