4	Date of Procedure	Same Day Surgery Dre Acces	ement Oraștinanies
Please answer the questions on this questionnaire and return it sedion leaves at suphysiolaridocoffice andre, after a factor it seems and providing transportation by our procedure. North:	Dazz Patient	Saute Day Surgery Fre Mases	singht Questionnaire
lare any questions please contact Same Day Surgary at 410-543-7037. Since it may be necessary to contact you prior to your procedure, lobease list your contact phone numbers: Home:	Please answer the questions on t	his questionnaire and return it before	is a voice the place to the property and a substantial property and a subst
To protect your privacy no messages will be left on recorders. Thank you. Patient's Name: Social Security # Type of Procedure you are having: Who is providing transportation home? Name: What medications do you take? List name, amount, how often & reason: 6	have any questions please contact Same D	lay Surgery at 410-543-7037. Since it	may be necessary to contact you prior to your procedure,
Patient's Name:	Home:	Work:	Cell:
No is providing transportation home? Name: What medications do you take? List name, amount, how often & reason: 1.	To protect your privacy no messa	ges will be left on recorders. Thank yo	NJ.
Nho is providing transportation home? Name: What medications do you take? List name, amount, how often & reason: 1. What medications do you take? List name, amount, how often & reason: 2. Are you taking herbal or vitamin suppleme 1. Yes No If yes, please list: 2. 7. 1. 3. 3. 4. 9. 3. 4. 9. 3. 4. 9. 4. 9. 4. 9. 4. 9. 4. 9. 4. 9. 4. 9. 4. 9. 4. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9.	Patient's Name:		Social Security #
Who is providing transportation home? Name: What medications do you'take? List name, amount, how often & reason: Comparison of the containing of the co			
1. What medications do you' take? List name, amount, how often & reason: 2. Are you taking herbal or vitamin suppleme 1			
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Please bring all medications in their containers at the time of your surgery) Have you ever had surgery in the past? Yes No (If necessary, use separate sheet of paper) 1	3	8	2
5	4	9	3
Please bring all medications in their containers at the time of your surgery) Have you ever had surgery in the past? Yes \(\) No \(\) (If necessary, use separate sheet of paper) 1. \(\) 2. \(\) 3. \(\) 4. \(\) Do you have any medical condition you feel your Anesthesiologist should know about? Yes \(\) No \(\) If yes, please list/explain: 1. \(\) 3. \(\) 2. \(\) Are you allergic to any drugs? Yes \(\) No \(\) If yes, please list medication name & reaction) 1. \(\) 3. \(\) 2. \(\) 4. \(\) Do you have any latex allergies? Yes \(\) No \(\) Food Allergies? \(\)	5	10	
Have wou ever had surgery in the past? Yes \(\) No \(\) (if necessary, use separate sheet of paper) 1		toinare at the time of	4
Are you allergic to any drugs? Yes No If yes, please list medication name & reaction) 1	2		
Do you have any medical condition you feel your Anesthesiologist should know about? Yes \(\) No \(\) If yes, please list/explain: 2			
2	. Do you have any medical condition you fe	eel your Anesthesiologist should know	about? Yes □ No □
Are you allergic to any drugs? Yes No If yes, please list medication name & reaction) 1			
1			
2	1		
Do you have any latex allergies? Yes □ No □ Food Allergies?	2		
Have you had x-rays done in which dye was used? Yes □ No □ If yes. Did you have a reaction to the dye? Yes □ No □			
	- Nilagana L		

Patient's Name:			Social Security #
<u>S4</u>	me Day S	urgery Pr	re Assessment Questionnaire Continued
8. Do you have a history of:			f. Drink alcohol: Yes O No O If yes, how much?
a. Chronic headaches	Yes 🗆	No 🗆	
Stroke	Yes 🗆	No 🗆	
Seizures	Yes	No 🗆	h. Diabetes Yes No
b. Heart Problems:	Yes 🗆	No 🗆	If yes, controlled with: Insulin Diet Diet Pills D
Chest pain	Yes 🗆	No 🗆	i. Cancer Yes D No D
2. Shortness of breath	Yes 🗆	No	If yes, what kind?
Rheumatic fever	Yes 🗆	No □	j. Thyroid problems Yes No
4. Heart Attacks	Yes 🗆	No 🗆	
5. Heart Surgery	Yes 🗅	No 🗆	3. 이용에 있으면 1. 이용
Recent Lipid Profile (for cholesterol)	Yes 🗆	No 🗆	To be the first the first that t
c. High Blood Pressure	Yes 🗆	No 🗆	(1975. 기원 인경, 전 J. 1975 전 1975 - 1985 - 1985 - 1985 - 1985 - 1985 - 1985 - 1985 - 1985 - 1985 - 1985 - 1985 - 1
Low Blood Pressure:	Yes C	No Q	14 3 4000000
d. Respiratory problems:	Yes 🗆	No 🗆	(1977) (1977) (1977) (1977) (1977) (1977) (1977)
1. Shortness of breath	Yes 🗀		,
2. Asthma	Yes 🗆		The state of the s
3. TB	Yes 🗆	No 🖸	
4. Emphysema	Yes 🗆	No 🗆	Lab washing to the state of the
5. Cough with phlegm or blood	Yes 🗆		V maries Van El Al El
			A-rays. Yes Li No Li
e. History of smoking year quit packs per day	Yes 🖸 how many	* 	EKG: Yes 🗆 No 🗔
e. History of smoking year quit packs per day Have you or any family member had problem.	Yes O how many ems with a	years	EKG: Yes No 🗆
e. History of smoking year quit packs per day	Yes () how many ems with a	years nesthesia	EKG: Yes No
e. History of smoking year quit packs per day Packs per day Have you or any family member had proble If yes, please explain In an emergency, do you accept blood train	Yes () how many ems with a	years nesthesia	EKG: Yes No
e. History of smoking year quit packs per day Place you or any family member had proble If yes, please explain In an emergency, do you accept blood train Females: Date of last period	Yes Co how many ems with a nsfusions o	years nesthesia or blood pr	EKG: Yes No
e. History of smoking year quit packs per day Have you or any family member had proble If yes, please explain In an emergency, do you accept blood train Females: Date of last period Are you pregnant?	Yes D how many ems with a	years nesthesia or blood pr	EKG: Yes No
e. History of smoking year quit packs per day Place you or any family member had proble If yes, please explain In an emergency, do you accept blood train Females: Date of last period	Yes D how many ems with a	years nesthesia or blood pr	EKG: Yes No
e. History of smoking year quit packs per day have you or any family member had proble if yes, please explain l. In an emergency, do you accept blood train f. Females: Date of last period Are you pregnant? Have you had past pregnancies? What form of birth control do you	Yes D how many ems with a nsfusions of Yes D Yes D use?	years nesthesia or blood pr No □ No □	EKG: Yes No
e. History of smoking year quit packs per day If year quit packs per day Packs per day If year quit packs per day Packs per day Packs per day If year quit packs per day Packs	Yes D how many ems with a nsfusions of Yes D Yes D use?	years nesthesia or blood pr No □ No □	EKG: Yes No 🗆
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e. History of smoking year quit packs per day have you or any family member had proble if yes, please explain have you accept blood train females: Date of last period Are you pregnant? Have you had past pregnancies? What form of birth control do you? Have you had all your childhood immunizate. Have you had the flu vaccine within the past. Have you had the pneumonia vaccine within the past. Do you wear? Glasses? Contact Lenses? Any capped or removable teeth? Do you have?	Yes D how many ems with an nsfusions of Yes D yes D use? tions? Ye st year? Ye n the last 2 Yes D Yes D Yes D	years nesthesia r blood pr No □	EKG: Yes No
e. History of smoking year quit packs per day 9. Have you or any family member had proble If yes, please explain 0. In an emergency, do you accept blood train 1. Females: Date of last period Are you pregnant? Have you had past pregnancies? What form of birth control do you 2. Have you had all your childhood immunizated. Have you had the flu vaccine within the past. 4. Have you had the pneumonia vaccine within the post. 5. Do you wear? Glasses? Contact Lenses? Globy ou wear dentures?	Yes D how many ems with an nsfusions of Yes D use? use? tions? Ye st year? Ye of the last 2 Yes D Yes D Yes D	years nesthesia* or blood pr No □	EKG: Yes No

