

Meadow Lane Surgery Center
 5652 Meadow Lane, New Port Richey, FL 34652

NAME: _____ ALLERGIES: _____
 (PRINT)

City/State of Birth _____ LATEX ALLERGIES: Yes NO _____

Procedures:			Current Medications:	Previous Anesthesia/Operations
Height	Weight <small>lbs/kg</small>	Age		

Have you ever had or still have:	YES	NO	Have you ever had or still have:	YES	NO
1. Reaction to anesthesia..... () self () mother () father () sibling	<input type="checkbox"/>	<input type="checkbox"/>	23. Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Smoke Tobacco Quit _____ packs per day _____ x _____ yrs.	<input type="checkbox"/>	<input type="checkbox"/>	24. MI Year _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Drink Alcohol..... Frequency _____	<input type="checkbox"/>	<input type="checkbox"/>	25. Irregular Rhythm	<input type="checkbox"/>	<input type="checkbox"/>
4. Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	26. Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Recent cold or flu.....	<input type="checkbox"/>	<input type="checkbox"/>	27. Hiatal Hernia / GERD.....	<input type="checkbox"/>	<input type="checkbox"/>
6. LMP..... Menopausal > 1 yr. _____	<input type="checkbox"/>	<input type="checkbox"/>	28. Auto Immune..... Rheumatoid Arthritis, HIV, AIDS, Lupus	<input type="checkbox"/>	<input type="checkbox"/>
7. Dentures ↑↓, Partials ↑↓, Caps ↑↓	<input type="checkbox"/>	<input type="checkbox"/>	29. Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Contact Lenses or Glasses	<input type="checkbox"/>	<input type="checkbox"/>	30. Motion Sickness.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Glaucoma..... Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	31. Diabetes NIDDM / IDDM.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Hearing Aids R L	<input type="checkbox"/>	<input type="checkbox"/>	32. Seizures/Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Shortness of Breath..... () at rest () exercising () sleeping	<input type="checkbox"/>	<input type="checkbox"/>	33. Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Bronchitis or Cough.....	<input type="checkbox"/>	<input type="checkbox"/>	34. Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	35. Radiation.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	36. Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
15. Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	37. Bladder/Kidney Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
16. Oxygen Liters _____	<input type="checkbox"/>	<input type="checkbox"/>	38. Body Piercing	<input type="checkbox"/>	<input type="checkbox"/>
17. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	39. Tattoos.....	<input type="checkbox"/>	<input type="checkbox"/>
18. Angina (Last Episode: _____)	<input type="checkbox"/>	<input type="checkbox"/>	40. Implants	<input type="checkbox"/>	<input type="checkbox"/>
How Relieved _____			41. Wheelchair, Walker or Cane	<input type="checkbox"/>	<input type="checkbox"/>
19. Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	42. Do you have any special communications needs? If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>
20. Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	43. Do you have a health care surrogate or durable power of attorney	<input type="checkbox"/>	<input type="checkbox"/>
21. Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Is it a Florida document?	<input type="checkbox"/>	<input type="checkbox"/>
22. Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Is it an out of state document?	<input type="checkbox"/>	<input type="checkbox"/>
			44. Instructed to provide photo I.D. at check-in	<input type="checkbox"/>	<input type="checkbox"/>
			45. Other	<input type="checkbox"/>	<input type="checkbox"/>

_____ PATS done per protocol
_____ Verbalized understanding of instructions
_____ Translator _____ DPOA / Surrogate
DATE _____ TIME _____ RN

DATE _____ TIME _____ CRNA/Anesthesiologist

Patient Label