

GEORGIA UROLOGY AMBULATORY SURGERY CENTER
2685 MILSCOTT DRIVE, DECATUR, GA 30033
TELEPHONE 404-292-7333

PLEASE PRINT, COMPLETE AND RETURN THE FOUR PAGE PRE-OPERATIVE HEALTH QUESTIONNAIRE WITHIN 5 DAYS OF RECEIVING YOUR DATE FOR SURGERY. YOU CAN FAX TO 404-292-3451 OR MAIL TO THE SURGERY CENTER AT THE ABOVE ADDRESS. IF YOU WISH TO SCAN AND EMAIL, PLEASE CALL THE SURGERY CENTER FOR INSTRUCTIONS.

NAME _____ DATE OF BIRTH _____

AGE _____ HEIGHT _____ FEET _____ INCHES WEIGHT _____ LBS.

Home phone _____ Day phone _____

Cell phone _____ E-mail _____

Pharmacy name _____ Pharmacy phone _____

Is English your primary language? Yes No If not, your primary language is:

Primary care doctor's name _____

Date last seen _____ Phone _____

Specialty physicians

Name _____ Specialty _____

Date last seen _____ Phone _____

Name _____ Specialty _____

Date last seen _____ Phone _____

ALLERGIES: I AM NOT ALLERGIC TO ANYTHING THAT I KNOW OF

PLEASE LIST ALL ALLERGIES

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

_____ Initial and date here, please

LAST NAME _____ DATE OF BIRTH _____

**MEDICATIONS: PLEASE LIST (WITH DOSAGE AND FREQUENCY)
ALL PRESCRIPTION, NON-PRESCRIPTION, OVER-THE-COUNTER
MEDICATIONS AND HERBAL PREPARATIONS YOU TAKE**

CHECK BOXES ARE FOR ASC INTERNAL USE

I TAKE NO MEDICATIONS

- _____ _____
- _____ _____
- _____ _____
- _____ _____

For ASC internal use: Instruct patient to take medications checked on the AM of surgery with a sip of water.

Anesthesiologist Signature

Date

PLEASE LIST ALL SURGERIES YOU HAVE HAD AND THE DATE(S)

OPERATION NAME

DATE

- 1 _____
- 2 _____
- 3 _____
- 4 _____

PLEASE TELL US ABOUT YOUR HEALTH. PLEASE READ EACH SECTION CAREFULLY AND CHECK ALL THAT APPLY.

1. Do you have or have had any breathing issues?

- Asthma
- Emphysema
- Chronic lung disease
- Sleep apnea
 - Mild
 - Moderate
 - Severe
- Use oxygen at home

_____ Initial and date here, please

LAST NAME _____

DATE OF BIRTH _____

- Sleep study
When? _____ Where? _____
 - C-PAP B-PAP
 - Loud snoring
 - Awaken from sleep with a choking sensation
 - Frequently wake up from sleep
 - Frequent daytime sleepiness or fatigue in spite of adequate sleep
 - Fall asleep easily in a non-stimulating environment (watching TV, reading, riding in or driving a car) in spite of adequate sleep
- What is your neck size? _____ inches

2. Do you have or have had any of the following heart or circulatory issues?

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Heart bypass surgery |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart artery stent(s) |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Angioplasty |
| <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Other blood vessel surgery |
| <input type="checkbox"/> Heart artery blockage | <input type="checkbox"/> Heart failure |

3. Do you have or have had any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Open areas on skin or draining sores |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Exposure to or current active infection |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Staph |
| <input type="checkbox"/> Difficulty breathing deeply | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Impaired mobility | |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Broken bone in face or jaw |
| <input type="checkbox"/> Gastric reflux disorder | <input type="checkbox"/> Jaw or nose surgery |
| <input type="checkbox"/> Kidney disorder | |
| <input type="checkbox"/> Liver disorder | <input type="checkbox"/> <u>Blood relative who ever had difficulty with anesthesia</u> |
| <input type="checkbox"/> Implant(s) of any kind | Who? _____ |
| <input type="checkbox"/> Lens <input type="checkbox"/> Shunt | What happened? |
| <input type="checkbox"/> Heart valve <input type="checkbox"/> Joint | _____ |
| <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Defibrillator | |
| <input type="checkbox"/> Pins, screws, rods or plates | |

_____ Initial and date here, please

LAST NAME _____ DATE OF BIRTH _____

4. Please tell us something about your lifestyle habits.

- I exercise regularly.
I exercise approximately _____ hours a week.
What kinds of exercise do you do? _____
- I don't exercise regularly.
- I smoke cigarettes. How many packs per day? _____ For how many years? _____
- I drink some alcohol. What kind? _____
How much and how often? _____
- I use some recreational substances. What kind? _____
How much and how often? _____

5. Have you had any of the following tests?

- Cardiogram (EKG) in the last 6 months? Where? _____
- Chest X-ray in the last 6 months? Where? _____
- Blood tests in the last month? Where? _____

If you have not had a cardiogram (EKG) in the last 6 months, when did you last have a cardiogram (EKG)? _____ Where? _____

6. Women:

- I am able to become pregnant. Date of last menstrual period: _____
 I have had a pregnancy test within the last 2 weeks.
- I have had a tubal ligation.
- I have had a hysterectomy.
- I am menopausal. Date of last menstrual period: _____

SIGN HERE, PLEASE

DATE OF COMPLETION

<p><i>For ASC internal use only:</i></p> <p>BMI _____</p> <p><input type="checkbox"/> Cleared for anesthesia</p> <p><input type="checkbox"/> Items needed for clearance:</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>_____ Anesthesiologist signature</p>	<p>_____ Date</p>

THANK YOU VERY MUCH FOR YOUR RESPONSES. A NURSE FROM THE SURGERY CENTER WILL CALL YOU TO CONFIRM THAT YOUR COMPLETED PREOPERATIVE QUESTIONNAIRE WAS RECEIVED. SHE MAY ASK YOU TO CLARIFY SOME OF YOUR RESPONSES.

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CALL THE GEORGIA UROLOGY ABULATORY SURGERY CENTER AT 404-292-7333 AND ASK TO SPEAK TO ONE OF THE PRE-OP NURSES.

THE GEORGIA UROLOGY AMBULATORY SURGERY CENTER IS HERE TO SERVE YOU. WE THANK YOU FOR TAKING THE TIME TO ASSIST IN PREPARING FOR YOUR UPCOMING SURGERY.