TAYLOR STATION
Surgical Center

## Taylor Station Patient History Form - 614-751-4466

Please include as much information as possible.

**Patient Name:** *
First Last

**Birthdate:** *
MM / DD / YYYY

**Age:** *

**Sex:** * Please select

**Height:** *

**Weight:** *

**BMI:** *
Please use calculator on the right to complete BMI ->

**Surgeon:** *

**Current pain level (0-10)**
**10 being worst pain:** * Please select

**Acceptable pain level (0-10)**
**10 being worst pain:** Please select

### Contact Numbers

**Home Phone:** * ### - ### - ####

**Work Phone:** ### - ### - ####

**Cell Phone:** ### - ### - ####

**Email:**

**May we leave a message?** *
Yes
No

**Allergies?** *

Please select
- Please select
- Yes (Please Explain Below)
- None
- Latex

**List All Known Allergies:**

**Procedure:**

**Date of Procedure:**

/ / 
MM DD YYYY

**Family Doctor:** *

**Phone Number:**

- -
### ### ####

**Fax Number:**

- -
### ### ####

**Recent Illness/Hospitalization:** *

- Yes
- No

**If yes, please explain:**

**Have you had a nutrition assessment?** *

- Yes
- No

**How is your appetite?** *

- Good
- Fair
- Poor

**Please explain your chief complaint/reason for procedure:** *

**Do you have an Advance Directive? If yes, please bring a copy with you the day of surgery.** *

- [ ] Yes
- [ ] No

**Do you have a Living Will or Health Care POA?** *

- [ ] Yes
- [ ] No

**Preferred Language:**

**Do you have special/educational needs?** *

- [ ] Yes
- [ ] No

**If yes, please explain:**

**Do you have someone to bring you, take you home and stay with you after surgery?** *

- [ ] Yes
- [ ] No

**Please provide names and phone numbers:**

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**Please indicate that you understand the following statements regarding pre-operative instruction**

**You will receive a call from the center notifying you of your procedure time and your arrival to center time 48-72 hours before your procedure.** *

- [ ] Yes
- [ ] No

**Do not bring valuables, jewelry or wear metal piercings of any kind. You will need co-pay / deductible the day of surgery.** *

- [ ] Yes
- [ ] No

**Bring insurance cards / Photo ID with you the day of surgery.** *

- [ ] Yes
- [ ] No

**Wear comfortable clothes the day of surgery.** *
- [ ] Yes
- [ ] No

**Do not bring children under the age 12 years old with you the day of surgery.** *
- [ ] Yes
- [ ] No

**Take a bath or shower the morning of or the night before surgery.** *
- [ ] Yes
- [ ] No

**During oral hygiene (brushing / flossing teeth) you can gargle or swish but do not swallow.** *
- [ ] Yes
- [ ] No

**After midnight, the night before surgery, do not have anything to eat or drink (no gum, mints, water, food, tobacco or liquids) Except colonoscopy 3 hours, and pain and endoscopy is 4 hours.** *
- [ ] Yes
- [ ] No

**Do not take medications before surgery except Blood Pressure medication or Heart medication. 1 Diabetics do not take medications, glucose levels will be monitored at surgical center. No water pills.** *
- [ ] Yes
- [ ] No

## Patient History Form

Please mark all that applies and all known problems:

**Anesthesia issues:** *
- [ ] No Known Issues
- [ ] post operative nausea and vomiting
- [ ] difficulty with airway
- [ ] malignant hypothermia or family history

**Snoring: Do you snore loudly (louder than talking or loud enough to be heard through doors?)** *
- ( ) Yes
- ( ) No

**Tiredness: Do you often feel tired, fatigued or sleepy during the daytime?** *
- ( ) Yes
- ( ) No

**Observed Apnea: Has anyone observed you stop breathing during your sleep?** *
- ( ) Yes
- ( ) No

**Pressure: Do you have or are you being treated for high blood pressure?** *
- ○ Yes
- ○ No

**BMI: Is your BMI greater than 35%?** *
- ○ Yes
- ○ No

**Age: > 50 years** *
- ○ Yes
- ○ No

**Neck Circumference: > 40 cm (16 inch shirt size)** *
- ○ Yes
- ○ No

**Gender: Male** *
- ○ Yes
- ○ No

## Cardiovascular

Check all that apply

**Cardiovascular:** *
- ☐ No Known Issues
- ☐ Bypass surgery
- ☐ Irregular heart rate
- ☐ Circulation problems
- ☐ Pacemaker / AICD
- ☐ Chest pain / angina
- ☐ Murmur
- ☐ High blood pressure
- ☐ Heart disease
- ☐ MI

**Pacemaker / AICD (Last interrogation date):**

**Blood thinners:** *
- ☐ Yes
- ☐ No

**Blood thinners, please list name and date last taken:**

**Cardiologist:**

**Phone number:** ☐ - ☐ - ☐
### ### ####

**Fax number:** ☐ - ☐ - ☐
### ### ####

## Neurovascular / Muscular

**Stroke / TIA (when?)**

**Blood clot (where?)**

**Artificial joint (date and joint)**

**Check all that apply:**

- [ ] No Known Issues
- [ ] Fibromyalgia
- [ ] Arthritis
- [ ] Epilepsy / Seizures
- [ ] Glaucoma
- [ ] Migraines

## Respiratory

**Respiratory:**

- [ ] No Known Issues
- [ ] Difficulty swallowing / breathing
- [ ] COPD
- [ ] Emphysema
- [ ] Lung Disease
- [ ] Bronchitis / Pneumonia
- [ ] Asthma
- [ ] TB

**Sleep apnea / C-PAP (setting)**

**Sleep study:**

- [ ] Yes
- [ ] No

**Sleep Study (when and where)**

**Sleep apnea / C-PAP**

- [ ] Yes
- [ ] No

## Gastrointestinal

**Gastrointestinal:**

- [ ] No Known Issues
- [ ] GERD
- [ ] Diverticulosis
- [ ] Diverticulitis
- [ ] IBS
- [ ] Crohns
- [ ] Colitis
- [ ] Polyp
- [ ] Ulcer

## Metabolic / Blood

**Metabolic / Blood:**

- [ ] No Known Issues
- [ ] Diabetes
- [ ] Hepatitis / Jaundice
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Hyperthyroid
- [ ] Hypothyroid
- [ ] Bleeding disorder
- [ ] Hemophilia
- [ ] Anemia
- [ ] Cancer (type below)

**Cancer (type):**

**Antibiotic resistant infection (type):**

**Abnormal EKG (explain):**

## Psycho-Social

**Psycho-Social:** *

- [ ] No Known Issues
- [ ] Unexplained weight loss
- [ ] Weight greater than 300lbs
- [ ] Tobacco use
- [ ] Illegal drug use
- [ ] Anxiety
- [ ] Depression
- [ ] Alcohol use
- [ ] Psychiatric disorder

**Alcohol use? If so how often?**

**Tobacco use? If so how often?**

**Psychiatric disorder (explain):**

## Reproductive

**Last menstrual cycle within the past year?**

- [ ] Yes
- [ ] No

**Last menstrual cycle date:**

**Lactating?**

- [ ] Yes
- [ ] No

## Family History

**Family Member (1):** * Please select

**Condition:** *

- [ ] No Known Issues
- [ ] Blood Clots
- [ ] Seizures
- [ ] Cancer
- [ ] Respiratory(chronic cough)
- [ ] Heart Disease
- [ ] Hypertension
- [ ] Diabetes
- [ ] Stroke

**Other:**

**Family Member (2):** Please select

**Condition**

- [ ] Heart Disease
- [ ] Hypertension
- [ ] Diabetes
- [ ] Stroke
- [ ] Blood Clots
- [ ] Seizures
- [ ] Cancer
- [ ] Respiratory(chronic cough)

**Family Member (3):** Please select ▾

**Condition**

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Diabetes
- ☐ Stroke
- ☐ Blood Clots
- ☐ Seizures
- ☐ Cancer
- ☐ Respiratory(chronic cough)

**Other:**

## Past Surgical History

**Surgical History:** *

- ☐ No prior surgery
- ☐ Heart/Bypass
- ☐ Skin
- ☐ Lower Back
- ☐ Lung
- ☐ Stomach
- ☐ Bowel Removal
- ☐ Kidney/Stone
- ☐ Appendix
- ☐ Prostate
- ☐ Hysterectomy
- ☐ Fracture
- ☐ Other
- ☐ Head/Brain
- ☐ Cataract
- ☐ Vascular
- ☐ Thyroid
- ☐ Hemorrhoid
- ☐ Gall Bladder

**Type of surgery and dates:**

Medication(s)

Do NOT take medications before surgery except:

Do take Blood pressure medicine without diuretic, and Heart medication.

Diabetics: Do NOT take oral diabetic medications but check with your doctor for instruction about insulin.

**Medication 1:**

Medication

**Dose:**

Dose

**Times a day:**

Times a day

**Reason:**

Reason

**Medication 2:**

Medication

**Dose:**

Dose

**Times a day:**

Times a day

**Reason:**

Reason

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**Medication 3:**

Medication

**Dose:**

Dose

**Times a day:**

Times a day

**Reason:**

Reason

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**Medication 4:**

Medication

**Dose:**

Dose

**Times a day:**

Times a day

**Reason:**

Reason

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**Additional Medications:**

Medication/Dose/Times a day/Reason

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