LaPorte Medical Group Surgical Center

La Porte Medical Group Surgical Center

Date Called_____Time_____N/Ans_____Message: Call Returned

PRE-OP CALL/SCREENING

Date of Surgery: _____ Patient Name: _____ Nickname:_____
Height: _____ Weight: _____ Phone Number:_____
Procedure: _____ Physician: _____
Expectation of Procedure: _____
Pre-Admission Testing: □Yes □No EKG □ Lab □ X-Ray □ Physical □ By Whom?_____
If you are female, could you be pregnant? _____ LMP_____
If Endoscopy Procedure: Was Prep ordered: Y □ N □ Type_____Did you receive prep instructions? Y / N
If unable to complete prep please notify your physician for further instructions.
SURGICAL HISTORY: Previous surgeries: _____
_____
MEDICATIONS: List all current medications - Including Vit/Herb Supplements (Dosage/Frequency): _____
_____
ALLERGIES: Medications:_____
_____
Food: _____ Latex: _____
MEDICAL HISTORY: Please check illnesses that apply to you or an immediate family member:

Cardiovascular		**Respiratory**		**G I**	
□ MI / Angina_____	_____	□ Asthma_____	_____	□ GERD /PUD	_____
□ Pacer / Stroke_____	_____	□ Bronchitis_____	_____	□ Hiatal Hernia	_____
□ Heart Failure_____	_____	□ Pneumonia_____	_____	□ Hepatitis/Cirrhosis	_____
□ Heart Murmur_____	_____	□ URI_____	_____	□ Fam Hx: Polyps	_____
□ HTN / Stroke	_____	□ COPD_____	_____	□ Colon Ca	_____
_____	_____	□ TB or Exposure____	_____	□ Chemo / Radiation	_____
_____	_____	□ Apnea / CPAP_____	_____	□ Incontinence	_____
Head & Neck	_____	**GU**		**Muscle /Skelatal**	
□ TMJ_____	_____	□ Kidney/Bladder	_____	□ Injuries/Surgeries___	_____
□ Caps/Crowns_____	_____	□ Renal Failure	_____	□ Arthritis / Weakenss_	_____
□ Dentures/Bridgework	_____	□ Retention	_____	□ Muscle Disease____	_____
□ Chipped/Loose Teeth /Braces_____		□ Incontinence	_____	**Neuro/Psych**	
□ Contacts _____	_____	□ Uterine/Prostate Ca	_____	□ Depression_____	_____
□ Cataracts/ IOLs_____	_____			□ Seizure / Stroke____	_____

Metabolic ---------- □ Diabetes_____ □ Thyroid_____

□ Steroids/ HRT_____ □ Free Bleeder_____ □ Tobacco Use: Qty:_____Years:____ □ Alcohol Use: Qty:____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
Prosthesis: implants, silicone or metal: _____
Have you or any of your relatives ever had a problem with anesthesia?_____ If yes, explain_____
_____
Are you prone to motion sickness? _____
Limitations/Special Needs? Please check all that apply
□ Language/Speech Barrier □ Interpreter Needed □ Hearing □ Hearing Aides
□ Mobility □ Walker/Crutches □ Vision □ Glasses/Contacts
□ Cultural/Religious Explain All Marked_____
Pre-op Instructions:
Arrival Time: _____ □ NPO; □ Comfortable Clothing; □ **No** Nail Polish, Body Piercings; □ Jewelry/Contacts Left at Home
Advanced Directive: □Yes □ No, if "Yes" please bring a copy. If "No" would you like information on? □Yes □ No, if "Yes" notify front office personnel
Medications to be taken day of Surgery: Heart or B/P Meds (w/sip of water by 0600); Insulin Inj: ½ dose NPH, full dose Regular evening before. No P.O.s or injectable Diabetic meds DOS. Take Asthma meds and bring with you.
Have you been instructed to stop any medications prior to having the surgery? Yes □ No □
Will you have a responsible adult to drive you home? Yes □ No □ (Only one person to be allowed in Pre-op area)
Who? _____ Contact Number: _____

Nurses Signature: _____ Date/Time: _____