Southwest Florida Institute Of Ambulatory Surgery, Inc.

Patient's Name: ______________________________

Age: __________ Height: ___________ Weight: __________

HISTORY AND PHYSICAL INFORMATION FOR S.F.I. SURGERY CENTER

PLEASE INDICATE BY A CHECK, YOUR ANSWER TO EACH QUESTION. THESE ANSWERS WILL GREATLY HELP YOUR PHYSICIAN TO GIVE YOU HIS/HER BEST CARE DURING YOUR OPERATION. IF YOU DO NOT UNDERSTAND ANY QUESTION (OR YOUR ANSWER IS UNCERTAIN) SIMPLY PLACE A QUESTION MARK (?) IN THE YES COLUMN AND OUR NURSES WILL ASSIST YOU DURING YOUR PRE-OPERATIVE EVALUATION.

PLEASE LIST NAMES AND PHONE NUMBERS OF ANY CURRENT MEDICAL DOCTORS.

1. ____ 2. ____
3. ____ 4. ____

HAVE YOU HAD OR STILL HAVE	YES	NO	EXPLANATIONS	HAVE YOU HAD OR STILL HAVE	YES	NO	EXPLANATIONS
Do you smoke?				Seizures?			
A cold in the past 2 weeks?				High Blood Pressure?			
Any lung trouble?				Heart Attacks-Heart problems?			
Do you drink alcoholic beverages?				Do you have a Pacemaker?			
				Stroke?			
Have you or your family had an unusual reaction to anesthesia?				An infectious disease such as MRSA, VRE, Hep, Aids, HIV?			
Have you or your family had any bleeding problems?				Thyroid Trouble?			
Any blood disorders?				Diabetes?			
Do you take any medications such as aspirin, or anti-inflammatory?				Low Blood Sugar?			
Do you take any form of "Blood Thinners"?				Kidney Trouble?			
Mitral Valve Prolapse?				Other illness not mentioned above?			
Rheumatic Fever?				Hiatal Hernia/ TMJ?			
Heart Murmur?				Do you have a Living Will?			

List all allergies to medications and reactions: ____________
____
____

Please list Medications and Dosages: ____________________________
____
____

Previous operations: Please list procedures and complications, if any. Begin with the most recent surgery. ____________________________
____
____

Any hospitalization or major illness? Begin with most recent hospitalization. ____________________________
____
____

Time and Place of most recent: Chest X-ray, EKG, Lab Tests, etc. ____________________________
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