Checkerspot Surgery Centers, LLC
Patient Medical & Surgical History

Name & phone number of person taking you home: _____

Is it okay to discuss care or discharge plan with your escort: ☐ Yes ☐ No

Please call immediately if you:

- ***have an artificial heart valve or joint replacement***
- ***have a pacemaker/internal defibrillator***
- ***are taking blood thinners (i.e. Coumadin, Plavix, etc.)***

Do you have Advance Directives, i.e., Living Will, etc., in place now? ☐ ***Yes*** ☐ ***No***
(If you currently have an Advance Directive in place, a copy of this is required for your records at Checkerspot Surgery Centers, LLC. Please bring a copy with you the day of your appointment.)

Please answer Yes or No to the following disorders and give any explanation necessary.

Disorder	Yes	No	Disorder	Yes	No
High blood pressure			Family history of colon cancer		
Heart attack / angina			Back / neck problems		
Congestive heart failure			Any joint replacement		
Heart murmur			Arthritis		
Mitral valve prolapse			Seizures		
Valve replacement			Stroke		
Cardiac surgery			Glaucoma		
Irregular heartbeat			Thyroid problems		
Internal defibrillator / pacemaker			Breast cancer		
Carotid stents			Endocarditis		
Asthma / emphysema / COPD			Bleeding disorders		
Lung disease / tuberculosis / other			Epilepsy		
Diabetes			Reflux esophagitis		
Stomach ulcer			Esophageal stricture		
Liver disease / hepatitis / other			Hiatal hernia		
Infectious disease / other			Polyps / colon polyps		
Kidney disease / other			Diverticulosis / Diverticulitis		
Bladder problems			Crohn's disease		
Ulcerative colitis			Irritable bowel / spastic colon		
Hemorrhoids			Other		
Ostomy					

Explanation: _____

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History / Condition	Yes	No	History / Condition	Yes	No
Any past major surgeries?			Allergies to medication?		
Other medical conditions?			Allergies to latex?		
Female only: are you pregnant?			Allergies to contrast (IVP dye)		

Explanation: _____

_____

Height _____ Weight _____

Have you had any problems with intravenous sedation?

☐ Yes ☐ No Describe _____

Check if you use any of the following:

Alcohol ☐ Yes ☐ No Quantity per day _____

Tobacco ☐ Yes ☐ No Quantity per day _____

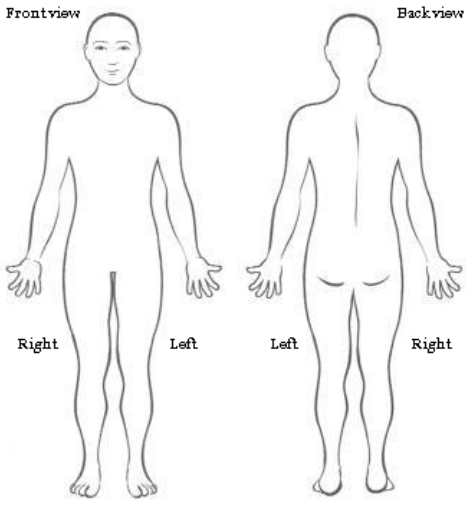
Narcotics ☐ Yes ☐ No Quantity per day _____

Circle the number that best describes your pain:
Your pain on average: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Your pain at its worse: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

(Guide:)
0 = no pain
5 = pain interferes with ability to do things
10 = worst pain imaginable

Where is your pain? How does it feel? Use the diagram below to show your main pain.

KEY
Stabbing / / /
Burning X X X
Pins and needles O O O
Aching Throbbing ^ ^ ^
Numbness - - -
Other . . .



I have received written information regarding my operating physician's credentials, including training, certification, and licensure.

_____ _____ _____ _____

Patient Signature *Date/Time* *Signature of Reviewing RN* *Date/Time*

Checkerspot Surgery Centers, LLC
Patient Medication Form

The staff at Checkerspot Surgery Centers wants you to understand the importance of managing your medications. Please use this form to list all prescriptions and non-prescription medications (*including over the counter products such as aspirin, herbal preparations and vitamin supplements*) that you currently take. **It is important you bring this form with you the day of your procedure. Thank you.**

We will add any new prescriptions given to you after your procedure and give you a copy of this form. Please keep a copy of this form with you, give it to your primary care physician and any other health care provider you encounter in the future (including any emergency room visits).

Name:	**Birth Date:**
List All Food and Drug Allergies and Describe Reaction:	☐ **No Allergies**

List <u>all</u> prescription and non-prescription (over-the-counter) medications including <u>vitamins, aspirin, and herbal preparations</u>.

Name of Medication "Home Medication List as Provided by Patient"	**Dose**	**How Often Taken?**	**Purpose**	**Date / Time Last Taken**

New Prescriptions (Given at discharge)

If you have any questions about your home medication, please contact your prescribing physician.