Temperature on Admittance _____

Respiratory Illness Signs & Symptoms Questionnaire for Patients

Please answer YES or NO to the following questions:	Please circle your response:
Have you recently felt feverish? Current or recent fever greater than 100.4 (38 C)	YES NO
Do you have a sore throat?	YES NO
Do you have a cough (not related to allergies or COPD)?	YES NO
Are you experiencing body aches?	YES NO
Are you experiencing shortness of breath?	YES NO
Do you have nasal congestion (not related to allergies or sinus infections)?	YES NO
Have you been in close contact with any person who may be sick with an influenza-like illness, coronavirus, Ebola, measles, MERS, SARS, or TB?	YES NO
Have you or anyone close to you traveled outside the US in the past 30 days? If yes: Name of Country and When? _____	YES NO

Patient Signature: _____

Today's Date _____ Time _____

Person completing this form: ☐ Patient ☐ Staff ☐ Patient Caregiver ☐ Visitor

Patient Label

NATIONAL AMBULATORY SURGERY CENTER

an affiliate of BASM

Gastroenterology Patient Questionnaire

1. Did you complete your bowel prep? YES NO
2. When was the last time you consumed solid food? _____
3. When was the last time you consumed any liquid? _____

   What did you drink? _____
4. What was the consistency of your last bowel movement?

   Circle One: Clear/Yellow or Solid Particles

Patient Signature _____ Date _____

Patient Label

NATIONAL AMBULATORY SURGERY CENTER LLC

PRE-OPERATIVE CALL

PROCEDURE: _____

SMOKER?	NO / YES	**PROVIDER:**	**ANES:**
ETOH DRINKER?	NO / YES	**DOS:**	
RECREATIONAL DRUGS?	NO / YES	**PATIENT:**	
DENTURES?	NO / YES	**DOB:** **AGE:**	**SEX:**
COLD / SORE THROAT PAST 2 WEEKS?	NO / YES	**HOME PHONE:**	**CELL:**
ALLERGIC TO IODINE?	NO / YES	**HEIGHT** _____	**WEIGHT** _____
ALLERGIC TO LATEX?	NO / YES	**LMP** _____	
ALLERGIC TO ANY MEDICINES?	NO / YES	**DATE LAST:** **EKG** _____	**LABS** _____
ANY OTHER ALLERGIES?	NO / YES		

MEDICATIONS

SURGICAL HISTORY / ANESTHESIA ISSUES

NOTES _____

SIGNIFICANT MEDICAL HISTORY

- ☐ None
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma/Bronchitis
- ☐ Blood Clot
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Excessive Bleeding
- ☐ Heart Attack
- ☐ Heartburn
- ☐ Heart Failure
- ☐ Hepatitis/Jaundice
- ☐ Hiatal Hernia/GERD
- ☐ Hypertension
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Seizures/Epilepsy
- ☐ Sleep Apnea
- ☐ Steroid Medication
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Water Retention
- ☐ Other...
- ☐ Other...

1. Do you have transportation home? YES/NO (circle one) Name: Phone:
2. Who will be taking care of patient at home (name):

INSTRUCTIONS:

1. Bring your insurance card as well as a check or credit card to cover any coinsurance or deductibles.
2. No food or drink after midnight or at least 8 hours BEFORE surgery.
3. If you are diabetic, do NOT take your meds on the day of surgery.
4. If you have high blood pressure, DO TAKE your meds as prescribed.
5. Do NOT shave or use a razor on or near the site of surgery.
6. Wear comfortable clothing: pull on pants and loose, button down or zippered top.
7. Please remove ALL jewelry, nail polish, make-up, lipsticks, lotions and eye contacts.
8. No chewing gum, tobacco, or smoking.
9. Please allow AT LEAST a full day for recovery, and do not schedule any appointments on the day of your surgery.

Patient agrees to and indicates a good understanding of all of these directions? YES / NO (circle one)

Called By _____ Date _____ Time _____ Left Message _____

Patient Signature _____ Date _____ Time _____

Summary of Medications

PATIENT STICKER	Pre-Op RN signature:	Initials:
	OR RN signature::	Initials:
	PACU RN signature::	Initials:

Medication Allergies	Patient Reaction	Physician and Anesthesia alerted	

Date	Routine Medications (If patient provides a list of medications a label must be placed and it must be stapled to this form)	Dose	Frequency	Last taken	Reason for taking Htn (Hypertension) ASHD (Arteriosclerotic Heart disease) CHF (Congestive Heart Failure) COPD (Chronic Obstructive pulmonary disease) ETC.

Date	Post Operative Medications	Dose	Frequency	Prescription provided at discharge		Prescription provided prior to admission		Comments
				Yes (directions provided) RN Initials	No RN Initials	Yes	RN Initials	

After discharge, if you have any questions about your medications, call your Physician.

Patient Signature

Time