Tri-State Centers for Sight Surgery Center
PATIENT HISTORY FORM

Please Complete and Bring this Form the Day of Surgery
Please fill out this form for <u>each</u> surgery done at the Surgery Center

Date: October 6, 2016
Name: «PName» **DOB:** «PDOB» **Chart #:** «PNumber»
Check YES or NO if you have had any of the following: (If multiple symptoms listed circle the ones that apply)

	Y	N	Comments		Y	N	Comments
Asthma				Claustrophobia			
**Coughing/Night Sweats Fever/Bloody Mucus				Ulcers/Bleeding			
	**Circle Symptom						
Emphysema				Hiatal Hernia			
Shortness of Breath				Kidney Problems			
Other Lung Problems				Urination Problems			
Smoker (how much)				Diabetes			
Heart Disease/Murmur				Low Blood Sugar			
Heart Attack(s) -- when				Thyroid Problems			
Irregular/fast Heartbeat				Convulsions/Epilepsy			
Chest Pain/Angina				Stroke/Paralysis			
High Blood Pressure				Easily Nauseated			
Low Blood Pressure				Hearing Problems			
Jaundice/Hepatitis				Contact Lenses			
Liver Trouble/Alcohol				Dentures			
Arthritis				Glaucoma			
Back Pain/Injury				Other Conditions			
Problems lying on back/				Previous Anesthesia/			
Breathing				Types/Problems:			
Anemia				Previous Surgery/			
Sickle Cell Disease				History of MRSA			
Bleeding Disorders				Family History:			
Blood Clot/When/Where				Heart/Lungs/Stroke			
				Seizures			

Height: Weight: Sex: M F
Vaccinations: Circle: **Y** or **N** Pneumococcal: **Y N** Influenza **Y N**
Home Infestations: Circle: Bed Bugs: Parasites:

MEDICATIONS ARE TO BE LISTED ON MEDICATION RECONCILATION FORM. THIS IS A CMS GOVERNEMENT REQUIREMENT FOR ALL PAITENTS RECEIVING TREATMENT.
SEE NEXT PAGE

Allergies:	Reactions:

Patient's Physician: Phone:

I have answered the above questions to the best of my ability

Patient's Signature: _____ Date: October 6, 2016

DO NOT WRITE BELOW THIS LINE

Mental Status -- This patient appears to be mentally competent	Physical Examination: (See Anesthesia Record)
YES _____ NO _____	Heart Lungs Other

This patient _____ is _____ is not medically cleared to undergo the planned surgery utilizing local anesthesia, monitored anesthesia care with an ambulatory surgery center as an acceptable setting.

x_____ Date:_____ x_____ Date: _____
Surgeon's Signature Anesthesiologist's Signature