MAGNA
SURGICAL CENTER LLC

9831 S. Western Avenue Chicago, IL 60643
(773) 445-9696

PRE-OP PHONE CALL AND ASSESSMENT

Procedure____

Time____________________ **Arrival Time**__________________

☐ Patient informed that a responsible adult must accompany the patient to and from this facility.
Name:____
☐ Patients encouraged to have a friend or relative stay with them the first 24 hrs
☐ Patient instructed to wear loose clothing, to wear no jewelry, cosmetics or nail polish, and to remove contact lenses.
☐ To bring their insurance card
☐ Diet Instructions:
NPO_______ Light Meal________ No Restrictions___________
☐ Pre-op testing needed:
CBC_________ Chem_________ EKG_________ Other________
.
Attempts to reach: 1.___________ 2.___________ 3.______________

Instructions given to:________________Detailed voice message______

MEDICAL HISTORY

Age_________ Height________ Weight________BMI_________
Do you: Smoke___________ Drink_________ Use Drugs________

Yes	No	
☐	☐	High Blood Pressure
☐	☐	Chest Pain
☐	☐	Heart attack Year:______
☐	☐	Irregular Heart Beats/Palpitations
☐	☐	Murmurs/Mitral Valve Prolapse
☐	☐	Pacemaker/Defibrillator
☐	☐	Congestive Heart Failure
☐	☐	Asthma: Do You Use An Inhaler?__________
☐	☐	Emphysema/COPD: Home O2_________
☐	☐	Bronchitis
☐	☐	Tuberculosis
☐	☐	Sleep Apnea / CPAP
☐	☐	Shortness of Breath with Rest / on Exertion / Lying flat
☐	☐	Cold/Cough within the last 2weeks
☐	☐	Sore throat / Fever / Productive cough
☐	☐	Loss of consciousness
☐	☐	Unexplained Dizziness
☐	☐	Seizure/Convulsions: Last Seizure___________
☐	☐	Stroke/Paralysis
☐	☐	Muscular Weakness/Tremors
☐	☐	UTI in the last 2 weeks
☐	☐	Jaundice
☐	☐	Hepatitis
☐	☐	Renal Insuffiency
☐	☐	Renal Failure: Dialysis________
☐	☐	Diabetes: How long/ Type_________ morning BS__________ Range__________
☐	☐	Hyperthyroid or Hypothyroid
☐	☐	GI bleeding or ulcers
☐	☐	Reflux/GERD
☐	☐	Hiatal Hernia
☐	☐	Inflammatory Bowel Disease
☐	☐	Cancer: Type____________RT_____ Chemo______
☐	☐	Bleeding Disorders or excessive bruising
☐	☐	Anemia
☐	☐	Blood Clots/ DVT
☐	☐	Sickle Cell Disease
☐	☐	Visual impairment/ Blind
☐	☐	Hearing impairment/ Hearing Aids
☐	☐	Any implants or prosthesis (heart valve, artificial hip or joint.) Explain:____
☐	☐	Need assistance for walking: Explain____ ____
☐	☐	Other____
☐	☐	**ADVANCED DIRECTIVE**
☐	☐	**AWARE OF RIGHTS & RESPONSIBILITIES**

Past Surgical History
____
____
____
____

Anesthesia History (Patient/Family)
___ Difficulty waking up, difficulty breathing with anesthesia or sedation
___ Nausea and vomiting with general
___ Difficulty opening mouth
___ History of Malignant Hyperthermia or temperature changes, heart problems

Allergies/Reactions____
____
____
____

LATEX ALLERGY Yes/ No

Comments:____

____

Medications/ Herbals see attached sheet and medications instructions

Signature________________________________ R.N. Date________

Signature________________________________ M.D Date________

Revised May '09