Print Form

ARUNDEL AMBULATORY SURGERY CENTER PATIENT PRE-OP ASSESSMENT FORM
FAX COMPLETED FORM TO (410) 224-6971

Name:		**Date of Birth:**
Procedure/Surgery:		**Surgeon:**
Home Phone #	**Cell Phone #**	**Work Phone #**
Vital Statistics: Sex:	Height:	Weight:
Next of kin/Responsible Driver:		**Phone#**

List all Allergies, including latex or indicate none	**Reactions**

Physical Limitations/Considerations

Vision:	☐ Glasses ☐ Contact Lenses ☐ Visual Deficits ☐ Other	
Hearing:	**Hearing Deficits:** ☐ Right ☐ Left **Hearing Aid:** ☐ Right ☐ Left	
Speech:	**Difficulty Speaking:** ☐ Yes ☐ No	
Activity Tolerance:	☐ Normal ☐ Crutches ☐ Cane ☐ Wheelchair ☐ Walker ☐ Prosthesis	
Smoking History:	**Current:** ☐ No ☐ Yes— Daily Amount:	**Past:** ☐ No ☐ Yes— Date Stopped:
Alcohol Intake:	☐ No ☐ Yes—Daily Amount:	Last Use:
Recreational Drug Use:	☐ No ☐ Yes— Type: Amount: Frequency: Last Use:	

Medical History (Indicate date of onset)

☐ Stroke_____
☐ Seizure_____
☐ Paralysis_____
☐ Other_____

☐ Diabetes_____
☐ Thyroid Disease_____
☐ Kidney Problems_____
☐ Bladder Problems_____
☐ Other_____

☐ Hepatitis_____
☐ GERD _____
☐ Intestinal Problems_____
☐ Ulcers_____
☐ Other_____

☐ LMP_____
☐ Hysterectomy_____
☐ Tubal Ligation_____
☐ Other_____

☐ Hypertension_____
☐ Angioplasty_____
☐ Chest Pains_____
☐ Irreg Heart Beat_____
☐ Heart Murmur_____
☐ Mitro Valve Prolapse_____

☐ Asthma_____
☐ CPOD_____
☐ Lung Disease_____
☐ Home Oxygen Use_____
☐ Trouble Breathing_____
☐ Sleep Apnea_____
☐ Productive Cough_____

Previous Surgeries or Other Medical Conditions (Indicate date)

Are you currently experiencing pain?

☐ No ☐ Yes — Where: _____

☐ Pain Rating 0-10 (0 indicates no pain; 10 indicates worst pain)_____

Describe your Pain: ☐ Burning ☐ Dull ☐ Sharp ☐ Shooting ☐ Heavy ☐ Continuous ☐ Cramping ☐ Pins & Needles

Completed by: _____ Date:_____

☐ Patient ☐ Other: _____