Bahamas SURGERY CENTER

Pre-Operative Evaluation

PATIENT LABEL

Patient Name: _____

Height: _____ Weight: _____

Check if history of:

RESPIRATORY
- ___ Recent Cold / Pneumonia
- ___ Lung Disease
- ___ COPD / Asthma / Emphysema
- ___ Sleep Apnea
- ___ Tuberculosis
- ___ Abnormal Chest X-Ray
- ___ Smoking _____ Packs Per Day

CARDIOVASCULAR
- ___ Heart attack: When _____
- ___ Congestive Heart Failure
- ___ Heart Murmurs
- ___ Chest Pain / Angina
- ___ Pacemaker / AICD
- ___ High Blood Pressure
- ___ Mitral Valve Prolapse

GI/GU
- ___ Ulcers/ Reflux
- ___ Irritable Bowel
- ___ Constipation / Diarrhea
- ___ Nausea / Vomiting
- ___ Hepatitis: Type_____
- ___ Liver Problems / Jaundice
- ___ Kidney Disease
- ___ Prostate Problems
- ___ Possibility of Pregnancy
- ___ Last Menstrual Cycle _____
- ___ Hysterectomy

INFECTIONS
- ___ Staph
- ___ Other _____

NEURO
- ___ Stroke: When _____
- ___ Transient Ischemic Attack
- ___ Seizures
- ___ Headaches / Migraines
- ___ Paralysis / Weakness
- ___ Fainting

MUSCULAR SKELETAL
- ___ Arthritis / Joint Pain / Swelling
- ___ Fractured Bones
- ___ Plates or Implants
- ___ Back or Disc Pain

ENDOCRINE
- ___ Diabetes
- ___ Insulin Dependant
- ___ Hyperthyroid or Hypothyroid

PSYCHIATRIC/SOCIAL
- ___ Mental Illness
- ___ Depression

BLOOD DISORDERS
- ___ Bleeding Disorder
- ___ Blood Disease (Anemia)
- ___ Blood Transfusions
- ___ Sickle Cell Trait
- ___ HIV/AIDS

DO YOU?
- ___ Wear Contact Lenses
- ___ Wear a Hearing Aid
- ___ Wear Dentures / Partials Plates / Bridge
- ___ Have Capped / Loose Teeth
- ___ Do you drink alcohol? If yes, amount _____
- ___ Recreational Drugs
- ___ Smoke / Chew Tobacco? If yes, amount _____

PREVIOUS SURGICAL HISTORY

Date of Last Anesthesia _____

Surgeries _____

___ Any history of abnormal reaction to anesthesia

___ Family history of reaction to anesthesia

Do you have an **Advance Directive**? _____

I received the information on patient rights, responsibilities, physician disclosure, notice of patient privacy and HIPAA, advance directive information and grievance policy, in advance of my surgery. I understand that if an adverse event occurs during my treatment at the surgery center, the personnel at the surgery center will initiate resuscitative or other stabilizing measures and transfer me to an acute care facility for further evaluation.

Patient Signature _____

BSC HOME MEDICATION RECONCILIATION LIST

Allergies to: Medications? ☐ No ☐ Yes Latex? ☐ No ☐ Yes
Shellfish or Iodine? ☐ No ☐ Yes

If answered YES to any of the above questions, please list allergy and reaction.

____

____

____

PATIENT LABEL

Are you currently taking any medications (prescription, over-the-counter, or vitamins) ☐ No Home Medications ☐ Yes, please fill out below.

☐ Allergies Reviewed
☐ NKDA

GREY AREAS FOR STAFF USE ONLY

Medication / Name / Dose	Frequency	Date & Time of Last Dose	RN Initial Reviewed	Continue on Discharge	Reason for Taking
Name: ______ Dose: ______	☐ Daily ☐ Bedtime ☐ 2 x a day ☐ 3 x a day ☐ Other ____			☐ Yes ☐ No ☐ New Med	
Name: ______ Dose: ______	☐ Daily ☐ Bedtime ☐ 2 x a day ☐ 3 x a day ☐ Other ____			☐ Yes ☐ No ☐ New Med	
Name: ______ Dose: ______	☐ Daily ☐ Bedtime ☐ 2 x a day ☐ 3 x a day ☐ Other ____			☐ Yes ☐ No ☐ New Med	
Name: ______ Dose: ______	☐ Daily ☐ Bedtime ☐ 2 x a day ☐ 3 x a day ☐ Other ____			☐ Yes ☐ No ☐ New Med	
Name: ______ Dose: ______	☐ Daily ☐ Bedtime ☐ 2 x a day ☐ 3 x a day ☐ Other ____			☐ Yes ☐ No ☐ New Med	
Name: ______ Dose: ______	☐ Daily ☐ Bedtime ☐ 2 x a day ☐ 3 x a day ☐ Other ____			☐ Yes ☐ No ☐ New Med	
Name: ______ Dose: ______	☐ Daily ☐ Bedtime ☐ 2 x a day ☐ 3 x a day ☐ Other ____			☐ Yes ☐ No ☐ New Med	
Name: ______ Dose: ______	☐ Daily ☐ Bedtime ☐ 2 x a day ☐ 3 x a day ☐ Other ____			☐ Yes ☐ No ☐ New Med	
Name: ______ Dose: ______	☐ Daily ☐ Bedtime ☐ 2 x a day ☐ 3 x a day ☐ Other ____			☐ Yes ☐ No ☐ New Med	
Name: ______ Dose: ______	☐ Daily ☐ Bedtime ☐ 2 x a day ☐ 3 x a day ☐ Other ____			☐ Yes ☐ No ☐ New Med	

NOTE: Avoid taking Tylenol & Tylenol containing products while taking any of the following pain medications – these medications contain Tylenol: Vicodin also known as Hydrocodone, Percocet also known as Oxycodone, Norco also known Hydrocodone

Pre-Op RN: ____________________ RN

Anesthesia review pre-op ____________________

Recovery RN: ____________________ RN

Surgeon Signature ____________________ MD

☐ Copy given to patient on discharge

Circulator RN Review ____________________