BELMONT HARLEM SURGERY CENTER

Thank you for choosing Belmont/Harlem Surgery Center. In order to get your surgery time scheduled this and sent back to B/HSC. We recommend using our online assessment www.belmontharlemsurgery.com/assessment to expedite the surgery process.

FORM NEEDS TO BE COMPLETED BY THE PATIENT.

Patient Name: _____

Date of Birth: __ /____ /_____ Height: ____ Weight: _____

Primary Care Physician (PCP): _____

PCP Phone Number: _____

Procedure to Schedule: _____

Surgeon Name: _____

CURRENT MEDICATION LIST OR ATTACH COPY (include name, dosage, frequency)

1. name: dosage: frequency:

2. name: dosage: frequency:

LIST ALLERGIES AND YOUR REACTION

1. reaction:

2. reaction:

SURGICAL HISTORY AND DATE

List any procedure with anesthesia

1. date __ /__ /_____

2. date __ /__ /_____

Please Check √ All The Boxes That Apply

ANESTHESIA HISTORY:

- ☐ Motion sickness nausea vomiting after anesthesia
- ☐ Difficult Intubation
- ☐ Any blood relatives with complications or effects related to anesthesia?
- ☐ No Issues with Anesthesia

MALIGNANT HYPERTHERMIA:

- ☐ Patient History ☐ Family History

Muscle Biopsy Done:

☐ Yes ☐ No

- ☐ No Malignant Hyperthermia Issues

NEUROLOGIC HISTORY:

- ☐ Anxiety ☐ Risk of Falls ☐ Vertigo
- ☐ Migraine ☐ Fainting ☐ Stroke
- ☐ Alzheimer's Disease ☐ Depression
- ☐ History of Seizures
- ☐ No Psychosocial Issues

CARDIOVASCULAR HISTORY:

- ☐ Pacemaker ☐ Implanted Defibrillator
- ☐ History of Heart Attack
- ☐ Congestive Heart Failure
- ☐ Valve Disease ☐ Chest Pain
- ☐ Irregular Heartbeat ☐ Murmur
- ☐ Coronary Artery Disease
- ☐ Hypertension
- ☐ Peripheral Artery Disease
- ☐ CABG ☐ Cardiac Stents
- ☐ Peripheral Edema
- ☐ History of DVT/PE
- ☐ Family History of DVT/PE
- ☐ No Cardiovascular Issues

RESPIRATORY HISTORY:

- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Sleep Apnea ☐ CPAP
- ☐ Flu Shot Date: ____ /_____ /_____
- ☐ Pneumonia Shot Date: ____ /_____ /_____
- ☐ 02 at night ☐ 02 all the time
- ☐ Cough ☐ Cough with Fever
- ☐ Asthma ☐ Emphysema
- ☐ Cold Symptoms
- ☐ Cold with Fever ☐ COPD
- ☐ TB ☐ Respirations

Recent travel outside of the country?

☐ Yes ☐ No

Current or Recent Respiratory Infection?

☐ Yes ☐ No

Smoke status:

packs/per day #____

how many years smoked #____

quit date _____ /___ /_____

- ☐ No Respiratory Issues

MUSCULOSKELETAL HISTORY:

- ☐ Arthritis ☐ Limited ROM
- ☐ Neck Problems ☐ Paralysis
- ☐ Back Problems ☐ Traction
- ☐ Amputations _____
- ☐ Prosthesis _____
- ☐ No Musculoskeletal Issues

SKIN HISTORY:

- ☐ Eczema ☐ Skin Cancer
- ☐ Psoriasis ☐ Intact
- ☐ No Skin Issues

HEMATOLOGY HISTORY:

- ☐ Anemia ☐ Blood Clots
- ☐ Bleeding Disorder ____
- ☐ Cancer History _____
- ☐ Chemotherapy and/or Radiation
- ☐ No Issues with Hematology

RENAL HISTORY:

- ☐ History of Renal Disease
- ☐ Dialysis _____
- ☐ Prostate Problems
- ☐ No Renal Issues

GASTROINTESTINAL HISTORY:

- ☐ C-Diff ☐ Gerd
- ☐ Hiatal Hernia ☐ Ulcers
- ☐ Liver Problems ☐ Gastritis
- ☐ Polyps ☐ Irritable Bowel
- ☐ Treatment for Alcoholism
- ☐ Excessive or Easy Bleeding
- ☐ Cirrhosis ☐ Hepatitis ____
- ☐ History of Blood/Plasma Transfusion
- ☐ Alcohol Use ☐ Illicit Drugs
- ☐ No Gastrointestinal Issues

GENITOURINARY HISTORY:

- ☐ Urinary Catheter
- ☐ Urinary Stent
- ☐ History of Incontinence
- ☐ Urostomy
- ☐ Recent UTI
- ☐ No Issues with Genitourinary

GYNECOLOGY HISTORY:

- ☐ Hysterectomy
- ☐ Post-Menopausal /no period for > 1 year

Last Menstrual Period:

date ____/____ /_____

- ☐ Not Applicable

ENDOCRINE HISTORY:

Diabetes: ☐ Type I ☐ Type II

- ☐ Hypoglycemia
- ☐ Thyroid Disease
- ☐ Steroid Therapy
- ☐ No Endocrine Issues

FORM STATEMENT

Did you complete this survey or did someone complete it for you?

- ☐ I completed this form
- ☐ Someone Else: write the name of person completing form

_____ .

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LIST ANY ADDITIONAL INFORMATION:

A representative from Belmont/Harlem Surgery Center will be contacting you regarding your arrival time for surgery. I verify this information is correct and to the best of my knowledge.

Patient Signature (required): _____ Date: _____ /_____ /_____