Patient Checklist

Please use this as a tool to expedite the check-in process.

On Surgery Day:

☐ DO NOT eat or drink anything after midnight, the night before your procedure unless you have been instructed otherwise.

☐ You will need a responsible adult to provide transportation home and care after your procedure.

☐ Wear comfortable, loose fitting clothing.

☐ Bring cases for eyeglasses, contact lens and dentures.

☐ Bring medical insurance cards, a picture ID and appropriate co-payment amount.

☐ Bring any x-rays, slings, crutches, ice machine or any other supplies your physician has provided.

☐ Bring the completed Medication list. – *see attached form*

☐ Bring the completed Anesthesia questionnaire. – *see attached form*

☐ Please leave all jewelry and valuables at home.

☐ Remove all body piercing before coming to the Center for Surgery.

rev. 5/2013

CENTER FOR SURGERY OF ENCINITAS

Anesthesia Questionnaire

Reviewers Initials: _____

Patient Name:_____ Date_____

Weight_____ Height_____ Age_____

Physical Activity Now: Little_____Moderate_____Active_____Very Active_____

Can you climb stairs? Yes_____No_____ More than one flight_____

YOUR ANESTHESIA HISTORY

What kind of anesthesia have you had? (circle all that apply)

General (Pentotal/Gas) Saddle Block/Spinal Nerve blocks Local injections

YES	NO	
		Have you or your family had any reactions, problems, or complications with anesthesia?
		Are you allergic to Latex?
		Have you been treated at this facility before?
		Have removable dentures, caps, loose or chipped teeth?
		Wear contact lenses, false eyelashes, false eyes?
		Have difficulty opening your mouth or moving your head or neck?

YOUR MEDICAL HISTORY (IF ANSWER IS YES, CIRCLE ALL THAT APPLY)

YES	NO	
		Bleeding Tendency, Hepatitis Jaundice Liver Trouble
		Lung Disease TB Asthma Wheezing Bronchitis Emphysema
		Do you currently have a Cough Cold
		Heart Disease Heart Attack-when? _____ Angina Chest Pain Irregular heart beat-what kind?_____
		Stroke-when_____ Epilepsy Convulsions Mental illness Nerve Paralysis Fainting Spell
		High Blood Pressure Diabetes Thyroid Disease Glaucoma Sickle Cell Anemia
		Present Drug Addiction List Drug(s)_____
		Have you taken illegal drugs What Drug(s)_____
		Do you smoke? How much_____ How Often_____Year Quit_____
		Drink alcohol? How much_____ How often_____ Alcohol withdrawal?_____
		Are you pregnant?
		Are you taking Aspirin, Blood thinners or NSAIDS? Date of last dose_____
		Do you snore? Have sleep apnea? Use C-PAP? Stop breathing during sleep? Daytime tiredness?
		History of sleep apnea or has anyone observed you stop breathing during sleep?
		Are you allergic to: Medications Foods Soap Tape Latex

List ALL allergies _____

List Previous Surgery (ies) _____

_____

Your anesthesiologist will talk and advise you regarding the type of anesthesia considered medically advisable. Modern day anesthesia is very safe. However, you should understand that, like other medical procedures, the administration of anesthesia is associated with certain risks. Major complications from anesthesia are extremely rare but they can result in death or disability. Please sign below when you have completed this form to the best of your knowledge and are satisfied you understand its contents.

Signature _____ **Relationship**_____

Center FOR Surgery OF ENCINITAS 477

Medication List

Name:_____

Date of Birth:_____

Allergies_____

Please complete this form and bring it on your day of surgery.

List the name, strength, how often and reason why you take medications.

Include **all** herbal and non prescription drugs.

Anesthesiologist & staff initials

DRUG NAME	STRENGTH	HOW OFTEN	REASON

NEW MEDICATIONS ADDED TODAY		

Copy given to pt _____ (initials)

Revised: 8/2010