



Health Questionnaire - Registration

Date of Surgery: _____ / _____ / _____ Scheduled Time of Arrival: _____ / _____ / _____
 Male: _____ Female: _____ Patient Age: _____ Height: _____ Weight: _____
 Scheduled Procedure: _____ Type of Anesthesia: _____
 Patient Cell Number: _____ Patient E-Mail Address: _____
 Name of Emergency Contact: _____ Telephone Number of Contact: _____
 Name of Escort: _____ Escort's Cell Number: _____

Does Patient Speak English? Yes _____ No _____ Language Spoken: _____
 Interpreter Needed? Yes _____ No _____

Source Of Information: Patient: _____ Significant Other: _____ Family Member: _____

Allergy Screen

Medication Allergies: None: _____ Yes: _____ What Drugs? _____
 Type of Reaction: _____

Food Allergies: None: _____ Eggs: _____ Shellfish: _____ Other: _____
 Type of Reaction: _____

Latex Allergy Screen: Have you ever had a reaction such as swelling, itching or difficulty breathing when exposed to latex rubber materials like gloves, condoms or balloons? No _____ Yes _____
 Type of Reaction: _____

If YES, complete the "Latex Allergy Screening Tool, attach and notify the Medical Director

Women of Childbearing Age? YES ___ NO ___ N/A ___

If YES, continue this section.

Last Menstrual Period: _____ Status Post Hysterectomy: _____
 Patient informed that a urine pregnancy test is performed on all women of child bearing age _____:

Personal Habits

Smoker: No _____ Yes _____ Packs per Day: _____ Years Smoking: _____
 Alcohol Consumed: No _____ Socially _____ Drinks per Day/Week _____
 Recreational Drugs: No _____ Yes _____ What Drug: _____ Last Used: _____
 Steroid Use: No _____ Yes _____ Type: _____ Last Used: _____

Primary Care Physician

Name:	Telephone Number:
Date of Last Visit:	Date of Pre-OP Visit:

Referring Physician, (if different from above):

General Information			
Name of Medicine	Dose	How Often	Special Instructions

Patient History - Check Any Illness You have Had or Presently Have

Cardiac N/A		Respiratory N/A		Musculoskeletal N/A	
Anemia		Asthma		Arthritis	
Bleeding Disorders		Inhaler Use		Joint Replacement	
Chest Pain		Chronic Lung Disease		Shoulder	
Chronic Edema		COPD		Hip/Knee	
Deep Vein Thrombosis		Pneumonia		Psychosocial N/A	
Heart Attack		Bronchitis		Depression	
Rheumatic Fever		Shortness of Breath		Anxiety	
Heart Murmur		Tuberculosis		Other N/A	
Prophylactic Antibiotics		Sleep Apnea		Cancer	
Heart Palpitations		(CPAP/BIPAP Use)		(Chemo/Radiation)	
High Blood Pressure		GI/GU N/A		Diabetes	
Irregular Heart Rate		Bladder Infections		(Diet Controlled)	
Pacemaker		Blood In Urine		(Insulin or Pill)	
Phlebitis		Colitis		(Fingersticks)	
Neurovascular N/A		Urine Frequency/ Urgency		Thyroid Disease	
Stroke		Diverticulitis		Hepatitis	
Numbness		Kidney Disease		HIV	
Seizures		Liver Disease		Herpes	
Migraines		Ulcers		Shingles	

Comment on any of the above checked and note any specialist being seen.

General Pain Information

Note pain location if you are currently experiencing pain: _____

Rate pain level 0—10 (0= no pain; 10= Worst pain you have ever had) _____

Describe pain: Burning _____ Stabbing _____ Aching _____ Other _____

What makes pain better? (Please Describe): _____

What level of pain do you feel is tolerable for you? _____

Prior Surgeries or Hospitalizations

Year	Type of Surgery or Reason for Hospitalization

Have you or any of your family members ever had a problem with anesthesia? Yes No If YES, please explain below.

Are you on Blood Thinners? Yes No

Do you bruise easily? Yes No

How often do you exercise?

What is your usual routine?

How many flights of stairs can you walk up easily?

Do you have or currently use a cane, crutches or wheelchair?

Do you have someone to take care of you when you arrive home?

Who? Family Friends

Do you have any Advance Directives? Yes No

What kind? Living Will Durable Power of Attorney DNR

Do you need information about Advance Directives?

Is there anything else we need to know about you that has not been addressed?

Notes:

Patient History Obtained By:

Date:

Time:

For your safety, a responsible adult must drive you home

Do not eat or drink anything after midnight, the night before your surgery, this includes chewing gum or sucking on candy

You may brush your teeth, but be careful not to swallow any water.

Bring a list of medications, including over the counter medications, vitamins and herbal remedies.

Take your normal complement of medicine with a tiny sip of water the morning of your surgery. Check with your primary care physician to obtain instructions on taking diabetic medicines, blood thinners or aspirin.

Bring your inhalers. If you have sleep apnea, bring your CPAP machine.

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Do not take any herbal remedies the morning of surgery.	
Shower or bathe the morning of your procedure or surgery.	
Do not wear makeup, lotions or creams.	
If you wear contacts, remove them and bring your glasses. Wear your hearing aids and dentures as normal. The nurses will remove your glasses, hearing aids and dentures or bridges before your surgery.	
Wear loose fitting, comfortable clothes, flat closed toed shoes and no jewelry.	
Bring crutches, cane, walker, braces or assistive devices with you, if needed.	
If you are responsible for any co-payments or deductibles, bring payment with you; otherwise leave all valuables at home.	
Bring your insurance card and photo ID.	
There is complimentary reserved parking at the front door of the Center.	
There is a waiting area for your family with periodicals, telephone and high speed wireless internet access.	
There is no cafeteria in the building.	
The address of the Center is: 6400 Goldsboro Road; Suite 400; Bethesda, MD 20817—www.massurg.com; 301-263-0800	
The following instructions were reviewed with the patient: Yes Telephone Message Left	
Since this is an unidentified voice mail, you will need to return our call at least 24 hours prior to your procedure for important information. Failure to do so may result in the rescheduling of your procedure to another day.	
For your safety, we require a complete list of all medicine you take. This list must include any vitamins, herbal medications and any “over the counter” medications you take, as well as your prescription medicine. Please bring this list with you.	
_____ Signature of Person Reviewing Instructions	_____ Date/Time
<p>Providing information: The patient is responsible for providing, to the best of his/her knowledge, accurate and complete information about the present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health. The patient has reviewed and/or completed all information on this form and has made changes as needed.</p> <p>This information remains confidential and will help us reach your goals for a safe recovery. We respect your privacy and ensure every effort is made to keep all information confidential. We may disclose your health information to provide treatment or service, to coordinate or manage your health care, or for medical consultations or referrals. We may disclose your health information to doctors, nurses, technicians and other personnel who are involved in taking care of you. We may use and disclose your health information so that we can receive payments for the treatments and services provided.</p> <p>I have received a copy and understand the Center’s Privacy Policy and the Patient’s Rights and Responsibilities.</p>	
_____ Patient Signature	_____ Date
_____ Patient Signature	_____ Date
_____ Patient Signature	_____ Date
The Massachusetts Avenue Surgery Center nurses thank you for sharing all your personal history. This information remains confidential and will help us reach your goals for a safe recovery. If there are any other concerns you feel we could assist with during your stay at the Center, please list them below and discuss them with your nurse.	