



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: _____

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):

Patient Disclosures

Did you receive a copy of the Center’s privacy policy. Patient Rights and Responsibilities, Physician Ownership and Advance Directives at least 24 hours prior to your surgery date Yes No

If no, you must contact the Center immediately. Arrangements must be made to provide this information to you. You may find it online at www.massurg.com or by telephone, fax or email.

Medication Reconciliation

Please see the attached Medication Reconciliation Form

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.

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Do not take any herbal remedies or vitamins seven (7) days prior to your 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

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

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.

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.

I have received a copy and understand the Center’s Privacy Policy and the Patient’s Rights and Responsibilities.

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.



Medication Reconciliation

Information Source : Patient Family Patient's List Other Facility List Other:

No Known Allergies Allergies and Reactions:

No Medications Taken At Home

Patient or Family: Please list all medications you are currently taking at home. Include over the counter medications and herbals.

Physician: Check medication instructions for patient.

Medication Name/Indicators	Dose	Route (oral, injection, other)	Frequency (daily, twice a day, other)	Last Dose (date & time)	Continue Medication	*Hold/Change Medication (see below)	Check with Your Physician Prescribing This Medication
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Home Medication Verified By:

Patient Signature/Date: _____ Nurses Signature/Date: _____

New Medication Prescribed at Discharge: (This is not a retail pharmacy prescription)	Dose	Route	Frequency	Prescription to Patient	Additional Medication Instructions:
				<input type="checkbox"/>	
				<input type="checkbox"/>	
*Medication Hold/Change/Other:				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	

Updated Medication List/Orders Reviewed with Patient/Designee and Copy Provided

Nurses Signature: _____ Date: _____

This procedure performed and the medications prescribed will have no affect on your current home medications.

Physician Signature: _____ Date: _____

I have received my medication instructions:

Patient Signature: _____ Date: _____