SANTA BARBARA SURGERY CENTER

ADULT HEALTH QUESTIONNAIRE PAGE 1

Please complete this questionnaire. The information you provide is important and will help us properly plan for your care on the day of your surgery or procedure. Please return the questionnaire to Santa Barbara Surgery Center as soon as possible, by secure fax (see below). You will receive a phone call from a pre-operative nurse before your surgery date, to review your health history and your physician's pre-surgery instructions, and answer any questions you might have.

DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE NIGHT BEFORE YOUR SURGERY/PROCEDURE.

NAME: _____ **PHONE (primary):** _____

AGE: _____ **WEIGHT:** _____ **SURGEON:** _____

DOB: _____ **HEIGHT:** _____ **DATE OF SURGERY:** _____

What surgery/procedure are you having? _____

YES	NO	Please check the YES or NO box for each question below. Where applicable, please circle information or fill in the blanks.	
		Have you ever been a patient at Santa Barbara Surgery Center before?	If so, when? (date)
		Have you had previous surgeries?	List:
		Any anesthesia complications?	List:
		Any family with anesthesia problems?	List:
		Neurologic problems?	Fainting / Seizure / Stroke / Headache / Migraines / Myasthenia / MS
		Any heart problems?	Heart Attack / Angina / Heart Failure / Heart Rhythm Abnormalities
		Any heart procedures?	Bypass / Valve Replacement / Angioplasty / Coronary Stent / Defibrillator
		Dates of heart problems / procedures?	
		Blood pressure problem?	High / Low Are you taking medications?
		Do you have sleep apnea?	Use Oxygen at Night / Use Positive Pressure Device (CPAP)
		Respiratory problems?	Pneumonia / Emphysema / Nighttime Dry Cough / Bronchitis / Asthma / Rhinitis
			Wheezing w/exercise / wheezing ≥ 3 times in last 12 months / Shortness of breath
		Do you smoke or vape?	How much? When did you quit?
		Infectious disease?	HepB / HepC / HIV / AIDS / Cold / Flu / Cough / Fever / History of Tuberculosis
		Diabetes?	List medications on Medicaton Sheet.
		Kidney or bladder problems?	Kidney failure / Dialysis / Stones / Infections -- Do you take flomax?
		Liver disease?	Jaundice / Hepatitis / Cirrhosis / Liver Failure / Alcohol -- How Much?_____
		GastroIntestinal problems?	Ulcer / Hiatal hernia / Reflux / Gastritis
		Have you had cancer?	Type: When?
		Pain/Physical problems?	Where? Walking / Back Pain / Neck Pain / Depression / Fall(s) / Other
		Mental health?	Depression / Anxiety / Other?

ADULT HEALTH QUESTIONNAIRE PAGE 2

PLEASE COMPLETE BOTH PAGES OF THIS FORM

YES	NO	Please check the YES or NO box for each question below. Where applicable, please circle information or fill in the blanks.	
		Blood or bleeding problems?	Anemia / Poor blood clotting / Too much clotting / Deep Vein Thrombosis
		Do you use aspirin or blood thinners?	Date of last use:
		Thyroid problems?	Hyperthyroid / Hypothyroid
		Dental or jaw problems?	Dentures / Caps / Loose teeth / TMJ / Trouble opening mouth
		Vision problems?	Glaucoma / Cataract / Eyeglasses / Contacts / Blindness
		Hearing problems?	Hearing Aid / Deafness
		Language interpretation needs?	Language?
		Do you use herbal remedies/recreational drugs?	Type:
		Any possibility of pregnancy?	

What is the name & phone number of your regular Medical Doctor ? _____

If you have heart problems, what is the name & number of your Cardiologist? _____

Have you ever had a treadmill test / angiogram / echocardiogram? Y / N If so, when? _____

Name of the responsible adult who will drive you home and be available to assist you as needed for the next 24 hours:

Primary Ph. #: _____ Secondary Ph. #: _____

Designated Power of Attorney Name (please bring person and/or documents): _____

Pharmacy Name & Location: _____

_____ _____

Patient Signature **Date/Time**

_____ _____

Reviewed by **Date/Time**

☐ **No Changes**

☐ **Changes Noted in Pre-op Assesment**

Please fax this 2-page form to 1(866) 297-5257. This is a secure, private fax number/machine.

Thank you for taking the time to provide us with this important information, which will help us provide the best care possible on your day of surgery. Our mission is to care for every patient and their family as if they were our own. Each patient, each family, each and every time. We hope you will be satisfied with your experience at Santa Barbara Surgery Center.

Medication Reconciliation

(Including prescriptions, over the counter medications, herbals, vitamins/minerals and birth control pills/patches)

Allergies	Type of Reaction Noted

Medication Name	Dose*	Frequency* *(how often?)*	Last Taken (Complete the day of surgery)	Instructions

❑ Patient unable to give detailed information. Reason: _____

Obtained from: ❑ Patient ❑ Spouse ❑ SO ❑ Prior Chart ❑ Other _____

POST SURGERY

New Prescriptions	Dose	Frequency *(how often?)*	Reason for taking	Last Taken *(if applicable)*	Instructions	Next dose to be taken at *(after discharge)*
❑ None						

❑ Copy given to patient with discharge instructions

Nurse Signature: _____ Date: _____ Time: _____

patient name