McDowell ambulatory surgery center

ASC ADMISSION ASSESSMENT

Welcome to McDowell Ambulatory Surgery Center! Our staff looks forward to the opportunity to serve as you go through your procedures. In order to assure a smooth check-in process, please complete this form in its entirety, and bring with you on the day of your procedure. Please feel free to contact us, should you have any questions.

Name: _____ Date of Birth: _____

- **List all drug allergies with corresponding reactions:**

DRUG NAME	REACTION

- **Have you ever had any reactions to any of the following? (Please circle all that apply or N/A) Contrast dye Iodine Adhesive tape/bandaides N/A**
- **List or attach all current medications:**

- **Do you take beta-blockers? YES NO NOT SURE List: _____**
- **Have you recently been prescribed, or are you currently taking any antibiotics? YES NO List any antibiotics you have taken in the last week and reason for taking:**

  _____
- **Are you currently taking any blood thinners? YES NO Circle all that apply:** Plavix (Clopidogrel); Lovenox (Enoxaparin); Pradaxa; Heparin; Aggrenox (Aspirin/dipyridamole); Ticlid (ticlopidine); Aggrastat (tirofiban); Integrilin (eptifibatide); Pletal (cilostazol); Arixtra (fondaparinux); Orgaran (danaparoid); Other: _____

  When was the last time you took your blood thinner? _____
- **Do you have any metal implants? YES NO List: _____**
- **Are you diabetic? YES NO**
- **Female Patients only please select: Post-menopausal Hysterectomy Neither**
- **List all prior surgeries:**

DATE/YEAR	PROCEDURE

- **Have you experienced complications related to sedation provided for previous procedures? NO NOT SURE YES – Please explain: _____**

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- **Health history: Check all that apply (related to YOURSELF ONLY – this is not familial)**

Cardiac: ____ Irregular heart rhythms ____ High blood pressure ____ Congestive heart failure ____ Pacemaker/Defibrillator ____ Other: _____ ____ None of the above	**Respiratory:** ____ Asthma ____ Bronchitis ____ Pneumonia ____ Emphysema ____ Chronic obstructive pulmonary disease ____ Difficulty breathing ____ Tuberculosis ____ Sleep apnea ____ Other: _____ ____ None of the above	**Neuro/Musculoskeletal:** ____ Seizures ____ Other: _____ ____ None of the above
Liver/GI: ____ Hepatitis B ____ Hepatitis C ____ Bowel incontinence ____ Other: _____ ____ None of the above	**Renal:** ____ Dialysis ____ Urinary incontinence ____ Other: _____ ____ None of the above	**Other:** ____ Current or recent infections ____ Cancer ____ Chemotherapy ____ Bleeding disorders ____ HIV ____ Other: _____ ____ None of the above
Life Style: Do you smoke? YES NO How often?_____ Do you drink alcohol? YES NO How often?_____ Do you use any recreational drugs? YES NO How often? _____		**Height: _____** **Weight: _____**

Patient Signature: _____ Date: _____

Please remember to show up at least 30 minutes prior to your scheduled procedure start time. Take time to review your pre-op instructions prior to your procedure. We look forward to meeting you!

REVIEWED BY: _____ , **RN** Date: _____