VALLEY AMBULATORY SURGERY CENTER

ST CHARLES, IL

630-584-9800 - FAX 630-584-9902

PATIENT HISTORY FORM

PATIENT NAME | SURGEON:

DATE OF SERVICE

PLEASE COMPLETE, RETURN IN THE ENCLOSED ENVELOPE/OR FAX TO 630-584-9902 AND BRING ORIGINAL WITH YOU THE DAY OF SURGERY

HAVE YOU HAD OR DO YOU STILL HAVE ANY OF THE FOLLOWING:

HEIGHT								
WEIGHT								
	Y	N		Y	N		Y	N
Sleep Apnea?			High Blood Pressure			Jaundice, hepatitis or		
A cold in past 2 weeks			Rheumatic fever			other liver trouble		
Shortness of breath			Chest pain, angina			Back injury		
Asthma			Heart Attack(s)			Convulsions, epilepsy		
Pneumonia			Fast or irregular heart beat			Polio, paralysis, meningitis		
Emphysema, resp. difficulty			Heart murmur, mitral valve prolapse			Arthritis		
Do you smoke?			Congestive heart failure			Tubal ligation		
Tuberculosis			Any other heart problems			Dentures, partials, loose teeth		
Any other lung disease			Anemia			Have you or your family had an		
Diabetes			Acid reflux			unusual reaction to anesthesia?		
Kidney trouble			Stroke			You or your family had history		
Malignant hyperthermia			Thyroid trouble			of bleeding problems?		
Blood clots in legs			Any other medical conditions			Do you drink alcohol?		
						Do you use recreational drugs?		
Have you ever had an EKG?								

When/where was last one taken?

ANY MEDICATION ALLERGIES? YES NO	CURRENT MEDICATIONS			DOSAGE/FREQUENCY
Please list.				
ANY OTHER ALLERGIES? YES NO				
LATEX ALLERGIES YES NO				
PREVIOUS SURGERIES	Herbal remedies			
	Steroids in last 6 mo.			
	Over the counter medications			

PRIMARY DOCTOR NAME/PHONE NUMBER:

	Y	N
DO YOU HAVE ADVANCE DIRECTIVES/LIVING WILL?		
I HAVE RECEIVED THE SPECIAL PATIENT INFORMATION/BILL OF RIGHTS BEFORE THE DAY OF SURGERY		

NURSES NOTES/COMMENTS

REVIEWED WITH PATIENT | RN | DATE:

PATIENT/GUARDIAN SIGNATURE: | DATE:

PLEASE FILL IN ENTIRE FORM AND SIGN BEFORE SUBMITTING