Summit Surgical
Pre Procedure Patient History Check-list

Today's Date:_____Patient's Name:_____ Date of Birth:_____
Height:_____ Weight:_____lbs. Sex: □ male □ female (Women) Are you pregnant now? □Yes □ No
Glasses: □ Yes □ No Contacts: □ Yes □ No Any chance of pregnancy now? □ No □ Yes
Beginning of last menstrual period: _____
Full name of person who will be driving you home:_____ Relationship:_____
Do we need to call someone to pick you up after your procedure: □ no □ yes:_____
Phone #:_____
Do you have any allergies to medications? □ No □ Yes: Please list allergies and reactions:
_____ _____ _____ _____
_____ _____ _____ _____

Check the following that apply:

Lung	**Vascular & GI/GU**	**Systemic**	**EENT**
___ Recent Bronchitis	___Congestive Heart Failure	___Convulsions/Epilepsy	___Cataracts
___Emphysema	___High Blood Pressure	___Parkinson's (tremors)	___Glaucoma
___Asthma	___Heart Attack ___yr.	___Seizures	___Recent Tonsillitis
___Chronic/A.M Cough	___Mitral Valve/Murmur	___Paralysis	___Ear Infections
___Recent Pneumonia	___Irregular/Fast Heart Beat	___AIDS Exposure	___Hard of Hearing
___Shortness of Breath	___Recent Chest Pain	___Thyroid Trouble	___Sinus Problems
___Recent "Cold"	___Cardiac Pacemaker	___Arthritis	___Seasonal Allergies
___Do you Smoke?	___Heartburn/Hiatal Hernia	___Diabetes- How controlled?	
How Much: ____	___Stroke or Mini Stroke	□ Insulin □ Diet □ Medication by Mouth	
How Long: ____	___Liver Problems	___Stomach Problems/Abdominal Pain/ Ulcers	
___Tuberculosis Exposure	___Kidney Failure/Dialysis	___Alcohol use, how often _____	
	___Bladder/Prostate Problems	___Hepatitis/Exposed Type: ____ When: ____	
	___Bowel Problems:	___Cancer Type: _____Diagnosed:_____	
	□ Polyps □ constipation		
	□ Diarrhea □ family history colon cancer		
	□ Rectal bleeding □ hemorrhoids		

List any medical conditions not listed: _____

Have you ever had an EKG? □ No □ Yes If so, when & where:_____

Do you use street drugs? □ No □ Yes
Are you on any of the following medications: □Aspirin □Plavix □Lovenox □Ticlid □Heparin □ Coumadin
□ Other anticoagulants (blood thinners) _____
List Current Medications, Doses and how often you take them (include Vitamins, Herbs & over the counter Medications)
_____ _____ _____
_____ _____ _____
_____ _____ _____
List prior surgeries and year performed:_____
_____
Have you ever had anesthesia?□No □Yes Have you or your family had any complications with it?□No □Yes
What? _____
Do you have dentures, partial plates, capped, broken or missing teeth? _____
*I acknowledge that in the event the bowel cleansing is incomplete, the procedure would need to be completed at a later date and additional expenses will incur.
Patient Signature:_____
SS 2003 revised 08/10, 9/10, 12/10