TEXARKANA SURGERY CENTER
ASSESSMENT FORM

Name ______________________

Date of Birth ______________________

Account # ______________________

Primary Contact Number ______________________

Language Spoken ______________________

Other Number you may be contacted at ______________________

____

Chest Pain/Angina/Heart Attack	Yes	No
Heart Murmurs	Yes	No
Rheumatic Fever	Yes	No
Palpitations	Yes	No
Pace Maker	Yes	No
High Blood Pressure	Yes	No
Stroke	Yes	No
Epilepsy/Convulsions/Seizures	Yes	No
Asthma/Bronchitis/Emphysema/Pneumonia	Yes	No
Shortness of breath/Sleep Apnea/CPAP or Bi-PAP	Yes	No
Tuberculosis	Yes	No
HIV/AIDS	Yes	No
Diabetes	Yes	No
Back/Neck Problems	Yes	No
Cancer	Yes	No
Recurrent Headaches	Yes	No
Hepatitis/Liver Disease/Yellow Jaundice	Yes	No
Thyroid Disorder	Yes	No
Kidney Disorder/Dialysis	Yes	No
Sickle Cell	Yes	No
Bleeding Tendency/Phlebitis/Blood Clots	Yes	No
Glaucoma/Eye Problems	Yes	No
Blood Transfusion	Yes	No
Blood Transfusion Reaction	Yes	No
Intestinal Disorders/Ulcers/Bleeding/Reflux	Yes	No
Lupus	Yes	No
Multiple Sclerosis	Yes	No
Other	Yes	No

Please list all past surgeries

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Do you have
Tape Sensitivity Yes / No Latex Allergy Yes / No

Do you have difficulty
Hearing- Yes / No Seeing- Yes / No Swallowing- Yes / No Chewing- Yes / No

Have you had recent changes in your (Circle all that apply)
Appetite / Weight / Bowel Elimination / Urination

Have you had any (Circle all that apply) Nausea / Vomiting / Recent Falls

Do you use or have the following? (Circle all that apply)
Dentures / Partial Plate / Glasses / Contacts / Use Oxygen (Route ___________, Amount __________)
Hearing Aid / Implant Devices / Artificial Limb/ Walker / Cane / Wheelchair

Do you smoke ___ NA Yes / No If yes, number of packs/Day _______

Drug or alcohol use ___NA Yes / No Frequency _______

Do you have a Living Will, Advance Directive or Power of Attorney? *Yes / No / NA*
If yes please bring it with you on day of surgery.
If yes were you informed of Surgery Center Policy. *Yes / No / NA*

How do you learn information best? (Circle one) Video/Literature/Discussion

Are your immunizations current Yes / No

Are you having any pain related to your procedure
Yes / No Scale (0-10) ___ Site _________________ Character _________________

Has the Patient and/or Family ever had a reaction to anesthesia medication before
Yes / No If yes explain____

Religion ______________________________
(Conference Room for meeting/prayer with Clergy is available)

Are you pregnant? ___ NA Yes / No Last Period _______________
Post Menopausal ___ NA Yes / No

Height __________ ***Weight*** __________ ***BMI*** _________

___NA ___ Phone Assessment _______________________________ ***Signature/Date/Time***

Patient Signature / Date ____

Patient Signature / Date ____

Patient Signature / Date ____