GOLDEN STATE UROLOGY

Pre-Operative Quick Check

Your Name: _____ **Date of Birth:** _____
Age: _____ **Height:** _____ **Weight:** _____
Best Contact Phone Number: _____ **Alternative Number:** _____
Email Address: _____

Primary Care Physician Name and Phone Number:_____

Are you allergic to LATEX? **Yes** **No**

Allergies to any medications? **Yes** **No** **If yes, list here:**_____

History of STAPH INFECTION? **Yes** **No**

Can you tolerate Vicodin? **Yes** **No** **Unsure** **If no, why?** _____

Do you require a translator to understand complex medical terminology? **Yes** **No**

Do you have, or have had, any of the following conditions:

Anemia:	Yes	No	Diabetes:	Yes	No	Type I Type II
Cardiac Problems:						
ex. stent MI chest pain	Yes	No	High Blood Pressure:		Yes	No
Hepatitis:	Yes	No	Liver Disease:		Yes	No
Emphysema:	Yes	No	Dialysis:		Yes	No
Sleep Apnea:	Yes	No	Peripheral Vascular Disease:		Yes	No
Chronic Obstructive Pulmonary Disease:	Yes	No	Blood clot or DVT:		Yes	No

If you answered YES to any of these conditions, please note if you are on any medications or under doctor supervision:

_____

_____

Have you had Chemotherapy/Radiation in the last 6 months: Yes No
Are you currently, or have you ever been on Dialysis? Yes No
Do you take any of the following medications:

Digoxin	Yes	No	Coumadin	Yes	No
Diuretics (water pill)	Yes	No	Lasix	Yes	No
MAO inhibitors	Yes	No	Asthma Medications	Yes	No
Plavix	Yes	No	Insulin	Yes	No

Do you smoke or have history of smoking? Yes No **Packs per day:** _____ **How long:** _____

Someone over the age of 18 yrs of age who will be driving you home:
Name: _____ **Phone Number:** _____
Pharmacy Name and Address: _____ **Telephone Number:** _____

All Patients please sign:

_____ _____
Signature **Date**