**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:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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**