# Highlands Medical Center

In partnership with Saint Thomas Health

Your pre-op appointment is scheduled for_____

Please be on time for your appointment. If you need to cancel or reschedule, call the Same Day Surgery Department at (931) 738-4145.

Checklist for your pre-op appointment:

*Please make sure you bring the following items below or your visit will be rescheduled.*

_____ Drivers License

_____ Insurance Card

_____ Completed Same Day Surgery form (fill out the ***ENTIRE*** form)

_____ Medication List (name, dosage, how often you take)

Please allow time for your pre-operative visit. You may have labs, x-rays, and/or other pre-op testing. This appointment may take up to an hour or more.

Thank you!

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Apply Patient Sticker Here

Time of Arrival: _____

Labs_____EKG_____CXR_____

## *Fill Out Completely*

Cell # _____Height: _____Weight: _____

Allergies and Reaction: _____

Food Likes:_____ Food Dislikes:_____

Pneumonia vaccine month/year: _____ Flu vaccine month/year:_____
Where did you receive these vaccines? _____
If staying overnight, would you like to receive any above vaccines? Yes No

Tobbaco Products: (circle) Never Former Current Cigarettes Cigars Snuff/Chewing Tobacco
Daily use:_____ How many years: _____ Year Quit: _____

Education: Grade High school GED Associates Bachelor Master

List primary care physician and other doctors/specialists: _____

Living Will/Power of Attorney? Yes No Copy on file here? Yes No (if not, please supply for our records)

HIV/AIDS MRSA Hepatitis A B C Other Infectious Diseases: _____

List **ALL** Previous Surgeries: Specify ***Left*** or ***Right***: _____

_____

_____

_____

Had you ever had any problems with anesthesia? Explain: _____

Do you have any implants? (plates, screws, pacemaker, stents, etc)_____

Have you ever had a blood transfusion? Explain why. Did you have any reactions during the transfusion?

_____

*Circle any that apply to your past history or current condition*

**ENT**

Glaucoma Glasses
Cataracts Contacts
Sinus problems Difficulty speaking
Difficulty hearing Difficulty swallowing
Dentures: Upper, lower, or both
Loose or missing teeth
Other: _____

**Cardiac**

Chest pain Palpitations
Murmur Slow heart rate
High blood pressure Fast heart rate
Low blood pressure Congestive heart failure
Heart bypass MI (heart attack)
Atrial fibrillation (A-fib) Pacemaker/Defibrillator
Other: _____

## Home Medication List

(Include: Inhalers, Insulins, Eye drops, Ear drops, etc)

| Medication Name | Dosage | How Often | Reason for taking |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| | | | |
| ***Surgery Use Only:*** | Glucose: | Lungs: | HR: Abd: |
| NPO: | Pain Level: | VS: | |
| Consents Signed: | HCG: | Lab Result: | |
| | | | |
| Time back from PACU: | | VS: | |
| Anesthesia/Blocks Type: | | 15 min: | |
| Dressings: | | Discharge: | |
| PACU Meds: | | | |
| Xrays Done: | | | |
| Crutches/Cam boot/Walker | | | |
| Dx Codes: | | | |

**Respiratory**

Asthma
Chronic bronchitis
COPD
Use of oxygen
CPAP/BIPAP
Emphysema
Pneumonia
Shortness of breath
Sleep apnea
Tuberculosis
Other: _____

**Gastric**

Ulcers
Rectal bleeding
Reflux
Hiatel hernia
Jaundice
Colon polyps
Hemorrhoids
Anorexia
Crohn's
Gastric bypass
Nausea
Vomiting
Obesity
Ulcerative Colitis
IBS
Other: _____

Alcohol use: Yes No Explain use: _____

Do you **use** or have a **history** of using any type of recreational drugs: (marijuana, cocaine, etc.)_____

If yes, when was the last time? _____

**Endocrine**

Low blood sugar
Type I diabetes
Type II diabetes
New onset diabetes
Insulin dependent
Low thyroid
High thyroid
Other: _____

**Urinary**

Renal failure
Kidney stone
Incontinence
Hemodialysis
Kidney disease
Other: _____

**Reproductive: Male**

Prostate issues
Erectile dysfunction
Scrotal issues
Other: _____

**Reproductive: Female**

Last menstrual cycle 1 2 3 4 weeks ago or _____
Hysterectomy
Vaginal bleeding
Abnormal Mammogram
Menopausal
Currently Lactating
Tubal ligation
Number of Children: ____ Other: _____

**Musculoskeletal**

Fractures
Carpal tunnel
Osteoarthritis
Neck issues
Back issues
Dislocations
Joint replacement
Rheumatoid arthritis
Neck surgery
Back surgery
Other: _____

**Neurological**

Alzheimers
Aneurysm
Bipolar
Dementia
Encephalitis
Head injury
Muscular Dystrophy
Seizure
Anxiety
Bells palsy
CVA/Stroke
Depression
Gullian-Barre Syndrome
Muscular Sclerosis
Parkinsons
TIA (mini-stroke)
Other: _____

Other conditions not listed above: _____

Cancer (list where) _____

Chemotherapy
Leukemia (any type)
Bleeding disorders
Radiation
Coagulation disorders

Would you like a visit from our hospital chaplain? Yes No

Pharmacy: _____Location: _____

Do you go to a pain clinic? Yes No Where and for what reason?_____

Are you employed? Yes No Occupation:_____

Who do you live with?_____

Name of driver present: _____ Phone number:_____