



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

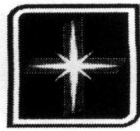
_____ Insurance Card

_____ 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!



Highlands Medical Center

In partnership with Saint Thomas Health

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

Tobacco 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			
<i>Surgery Use Only:</i>	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 Emphysema
Chronic bronchitis Pneumonia
COPD Shortness of breath
Use of oxygen Sleep apnea
CPAP/BIPAP Tuberculosis
Other: _____

Gastric

Ulcers Colon polyps Nausea
Rectal bleeding Hemorrhoids Vomiting
Reflux Anorexia Obesity
Hiatal hernia Crohn's Ulcerative Colitis
Jaundice Gastric bypass 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 Insulin dependent
Type I diabetes Low thyroid
Type II diabetes High thyroid
New onset diabetes
Other: _____

Urinary

Renal failure Hemodialysis
Kidney stone Kidney disease
Incontinence
Other: _____

Reproductive: Male

Prostate issues Scrotal issues
Erectile dysfunction
Other: _____

Reproductive: Female

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

Musculoskeletal

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

Neurological

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

Other conditions not listed above: _____

Cancer (list where) _____

Chemotherapy Radiation

Leukemia (any type) Coagulation disorders

Bleeding 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: _____