

SURGERY CENTER OF POTOMAC

Allergies: _____

Latex allergy: _____ Type of reaction:(rash, difficulty breathing): _____

<p>MEDICAL HISTORY: (Check if positive, and comment below)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Heart Disease</td> <td style="width: 33%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Renal/Kidney Disease</td> <td style="width: 33%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Bulimia</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Infection or sepsis<1 month</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Bladder Trouble</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Eating Disorder</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Heart Attack</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Bleeding disorder</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Hiatal hernia</td> </tr> <tr> <td style="vertical-align: top; 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Snore louder than talking yes/no</p> <p>2. Snore 3 or more times a week yes/no</p> <p>3. Pause in breathing 3 or more times a week yes/no</p> <hr/> <p>ARE YOU:</p> <p>1. Tired after sleeping 3 or more times a week yes/no</p> <p>2. Have you fallen asleep while driving yes/no</p> <hr/> <p>HYPERTENSION HISTORY:</p> <p>_____</p> <p>_____</p> <p>_____</p> <hr/> <p>THIS SECTION FOR STAFF TO COMPLETE Calculate BMI>30</p>
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Current Medication: Prescription name, Over the Counter, Herbal medications and Vitamins, dosage and frequency

Medication	Dosage	Frequency	Oral contraceptive
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	Hormone replacement therapy
_____	_____	_____	_____

Substance Use: (Check if positive and Quantify)

_____ Tobacco _____ Packs/day _____ Number of years _____ Coffee/Tea

_____ Alcohol Type: _____ Frequency _____

_____ Recreational Drugs Type: _____ Frequency _____

Post Surgical History/Hospitalization:

Date of last Anesthesia _____ Complication: _____

Hx of Anesthesia Recall? Yes _____ No _____

Patient Signature: _____ Date: _____

SURGERY CENTER OF POTOMAC

SURGERY & ANESTHESIA HISTORY & PHYSICAL

Date of Surgery: _____ Surgeon of Record: _____

Chief complaint/ Preoperative Diagnosis

_____ Micromastia _____ Macromastia _____ Capsular contracture
_____ Ptosis-Circle (eyelids, breasts, brow)
_____ Laxity-Circle (face, neck, abdomen, arms, thighs, buttocks)
_____ Lipodystrophy
_____ Nasal deformity-Circle (deviated, septum, nasal obstruction)
_____ Other: _____

PHYSICAL EXAMINATION:

Temperature: _____ SaO₂ _____
BP: _____ Pulse: _____ Respiration: _____ Weight: _____ Height: _____
HEENT: _____
Lungs: _____
Heart: _____
Abdomen: _____
Extremities: _____
Neurological: _____
Other: _____

Medical diagnosis (if applicable): _____
_____ No change in pts. H & P since: _____ except: _____

This evaluation includes the following:

_____ CBC with diff	_____ Medical Clearance
_____ Urinalysis	_____ Stress Test
_____ Chem-7	_____ Echo
_____ Chest X-ray	
_____ EKG	

Airway evaluation: Class _____ I, _____ II, _____ III, _____ IV
_____ Dental
_____ Head & Neck NPO after _____
_____ Other

Asa Status: _____ I, _____ II, _____ III, _____ IV, _____ V, _____ E
Planned Anesthesia: GA, MAC, IV sedation, Regional Block (specify) _____

The risks and benefits of GA, Reg., and IV sedation have been discussed and the patient is agreeable to (circle) General Anesthesia, Regional Anesthesia, Local/sedation.

H & P verified by: M. D. _____ Date: _____

Anesthesia Provider: _____ Date: _____

Patient Signature: _____ Date: _____

Translator: _____ Transporter/care giver at home: _____