Monticello Community Surgery Center

Date of Surgery	Surgeon	Type of Surgery		
Patient Name		Age	Height	Weight

Yes No

☐ ☐ Previous surgery/anesthesia? List what & when _____

☐ ☐ Have you, or a blood relative, had any problems with anesthesia, including: nausea, weakness, difficulty breathing or high fever? If yes, explain:_____

For Children under age 18:

Yes	No		Yes	No	
☐	☐	Premature birth	☐	☐	Heart problems after birth
☐	☐	Breathing problems after birth	☐	☐	Respiratory illness in the past month
☐	☐	Other conditions being treated for:_____ _____	☐	☐	Family history of muscle disease

For Ages 18 and Older:

Yes	No		Yes	No	
☐	☐	Heart attack–when _____	☐	☐	Chronic pain
☐	☐	Heart surgery-If yes, what & when _____ _____	☐	☐	Thyroid disorder
☐	☐	Pacemaker/internal defibrillator	☐	☐	Stroke – when _____
☐	☐	Congestive heart failure	☐	☐	Seizures – type _____
☐	☐	Angina/chest pain	☐	☐	Frequent heartburn, hiatal hernia, reflux
☐	☐	Heart murmur requiring treatment	☐	☐	Diabetes/glucose intolerance
☐	☐	Irregular heartbeat			average morning blood sugar _____
☐	☐	Last EKG: when & where_____	☐	☐	Bleeding problems/blood clots
☐	☐	High blood pressure	☐	☐	Sickle cell disease or trait
☐	☐	Elevated cholesterol	☐	☐	Hepatitis or jaundice
☐	☐	Fainting spells	☐	☐	Cancer – of what & when_____
☐	☐	Shortness of breath	☐	☐	Kidney disease/dialysis
☐	☐	Asthma/wheezing	☐	☐	Mediport, portacath, vein shunt
☐	☐	Emphysema/chronic bronchitis or/lung disease	☐	☐	Prosthesis/implants _____
☐	☐	Snore/been told you stop breathing while you sleep	☐	☐	Body piercings/jewelry
☐	☐	Frequent morning headaches or fall asleep easily during the day	☐	☐	A communicable disease (i.e., TB, HIV, VD, Hepatitis, MRSA, VRE) Type _____
☐	☐	Sleep apnea	☐	☐	Are you pregnant? Last menstral period _____
☐	☐	Use or been prescribed CPAP/BiPAP machine	☐	☐	Smoke: packs per day _____
☐	☐	Back/neck surgery or problems	☐	☐	Ever smoked in the past? If yes, quit when? _____
☐	☐	Arthritis requiring treatment	☐	☐	Drink alcohol regularly/how much? _____
☐	☐	Problems opening mouth (TMJ)	☐	☐	Object to blood transfusions
☐	☐	Numbness/weakness of muscles-If yes, where _____	☐	☐	Dentures/partials/loose or chipped teeth
					Other conditions being treated for _____ _____

What is the most activity you can do before you get tired or short of breath and have to stop?

☐ Walk across room ☐ Walk one block ☐ Walk one mile ☐ Run a mile

If one block or less, what limits your activity? _____

Any other information you feel the anesthesiologist should know? _____

ANESTHESIA PREOPERATIVE QUESTIONAIRE

Monticello Community Surgery Center

Patient Label

Medication Reconciliation Record

TO BE COMPLETED BEFORE SURGERY: Patient's medication list (patient or family to complete)

Patient Name:_____ **Date list written:**_____

Please Circle : Information provided by: **Patient** **Family** **Other** _____

ALLERGIES: ☐ **Denies** ☐ **Latex Sensitivity Reaction:**_____

Meds/Foods/Dyes/Other	Reaction	Meds/Foods/Dyes/Other	Reaction

Include all prescription medicines, over-the-counter medicines, herbal supplements, dietary supplements, vitamins, drug patches, eye drops, etc. taken by the patient.

Fill in this section only- please PRINT

Medication Name	Dose (Amount Taken)	Frequency (How Often)	Route (How Taken)	What do you take this for?	Staff Use Only SPECIAL INSTRUCTIONS If Needed, this will be completed and initialed by surgery center staff

TO BE COMPLETED AFTER SURGERY:

After your surgery, **CONTINUE** all of your medications as you have been taking them unless there are special instructions written above. **IF** new medications are prescribed, they are listed below.

The treating physician has not altered your routine home medication regimen provided on your admission, unless specifically indicated. For your safety, please review this information with your personal physician as part of your follow-up.

Patient's representative's signature: _____ Date:_____

Nurse's signature:_____ Date:_____

TAKE THIS LIST WITH YOU TO ANY FUTURE DOCTOR APPOINTMENTS OR TESTS

Monticello Community Surgery Center Registration Information

Personal Information

Have you had any previous surgeries at this location? ☐ **Yes** ☐ **No**

Are you presently residing in a Skilled Nursing Facility? ☐ **Yes** ☐ **No**

Last Name:_____ **First Name:** _____ **Middle Initial:** _____

Maiden or Previous Name:_____ **Date of Birth (MM/DD/YYYY):**_____

SSN:_____ **Sex:** Male Female **Race:** _____ **Marital Status:** _____

Mailing Address:_____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Do you have an advanced medical directive? ☐ **Yes** ☐ **No**

Would you like information about medical directives? ☐ **Yes** ☐ **No**

Emergency Contact

Name:_____ **Daytime Phone:** _____ **Cell Phone:**_____

Employment Information

Occupation_____ **Employer:**_____

Employer's Mailing Address: _____ **Phone:** _____

City:_____ **State:**_____ **Zip:**_____

Insurance Information

Primary Insurance Company Name:_____

Subscriber's Name:_____ **Subscriber's DOB:**_____

Subscriber's Relationship to Patient: _____

Secondary Insurance Company Name:_____

Subscriber's Name:_____ **Subscriber's DOB:**_____

Subscriber's Relationship to Patient: _____

MONTICELLO COMMUNITY SURGERY CENTER

RISK ASSESSMENT FOR OBSTRUCTIVE SLEEP APNEA

(To be completed for patients 18 years and older)

Patient Name:_____

Have you been diagnosed with Sleep Apnea? Yes_____ No_____

Have you had a sleep study? Yes_____ No_____

Do you use CPAP or BiPAP at home? Yes_____ No_____

If so , what are the settings? _____

SNORE Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
TIRED Do you fall asleep during the day?	Yes	No
OBSERVED APNEA Has anyone observed you stop breathing during your sleep?	Yes	No
BLOOD PRESSURE (HTN) Do you have High Blood Pressure?	Yes	No
Age greater than 50	Yes	No
Gender- Male	Yes	No

Height _____

Weight _____

COMMENTS: _____

_____

_____

Completed by: _____ Date: _____

Patient Sticker

Outcome PQRS Patient ID: _____ Practice/Surgeon's Name: _____

Site ID as seen in PQRS Registry: _____

Pre-Surgery Visual Functioning VF-8R Patient Questionnaire

Do you have difficulty, even with glasses with the following activities?

1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
2. Reading a newspaper or book?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
3. Seeing steps, stairs or curbs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
4. Reading traffic signs, street signs or store signs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
6. Writing checks or filling out forms?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
7. Playing games such as bingo, dominos, card games or mahjong?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
8. Watching television?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity