CENTER FOR AMBULATORY SURGERY
550 ORCHARD PARK RD. WEST SENECA, NY 14224

PLEASE FILL OUT PRIOR TO AND BRING TO APPOINTMENT

Sticker

PATIENT HISTORY

(Please use black ink only)

Procedure _____

Height _____ Weight _____

BMI _____

Primary Doctor _____

_____

Allergies:

_____

_____

_____

_____

Past Surgery / Year:

_____

_____

_____

_____

Activity:

Walk Independently	___Yes	___No
Cane	___Yes	___No
Walker	___Yes	___No
Wheelchair	___Yes	___No
Have you fallen in the last three months:	___Yes	___No

Do you take antibiotics prior to procedures ___Yes ___No

Why? _____

_____

Do you have Advanced Directives?

Yes	No	
❑	❑	Health Care Proxy
❑	❑	Living Will
❑	❑	DNR*- Do Not Resuscitate
❑	❑	MOLST* Medical Orders for Life Sustaining Treatment

❑ Yes ❑ N/A ***The CAS will always attempt to resuscitate you and transfer you to a hospital in the event of unexpected deterioration or adverse event.**

Were you born between 1945 and 1965?
The CDC recommends being tested for Hepatitis
Have you been tested? ___Yes ___No
If no, Patient notified to contact primary MD ___Yes ___No___N/A _____RN Initials

SEE REVERSE SIDE

PATIENT HISTORY

(Please use black ink only)

Sticker

Yes	No	
☐	☐	Smokes
☐	☐	Packs Per Day_____
☐	☐	Alcohol Daily amount_____
☐	☐	Recreational Drugs
☐	☐	Sedation Problems
☐	☐	Diabetic
☐	☐	Diet Control
☐	☐	Non-Insulin Dependent
		Type Insulin _____ Last Dose/Time _____ _____
☐	☐	Glucose Test Time _____ Reading _____
☐	☐	Thyroid Disease
☐	☐	Shingles
☐	☐	Alzheimer Disease
☐	☐	Parkinsons Disease
☐	☐	Restless Leg Syndrome
☐	☐	Dementia
☐	☐	Multiple Sclerosis
☐	☐	Stroke When_____
☐	☐	Seizures Last Seizure: _____

Yes	No	
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	COPD
☐	☐	Tuberculosis
☐	☐	Bronchitis
☐	☐	Sleep Apnea
☐	☐	C/PAP
☐	☐	BiPAP
☐	☐	Oxygen at Home
☐	☐	Heart Attack When _____
☐	☐	Heart Surgery
☐	☐	Chest Pain
☐	☐	Murmur
☐	☐	Valve Replacement
☐	☐	Pacemaker
☐	☐	Defibrillator
☐	☐	Irregular Heart Rate
☐	☐	Atrial Fibrillation
☐	☐	High Blood Pressure
☐	☐	Blood Clots
☐	☐	Congestive Heart Failure
☐	☐	Bleeding Problems
☐	☐	Anemia

Yes	No	
☐	☐	Abnormal Pain
☐	☐	Reflux (GERD)
☐	☐	Barretts Esophagus
☐	☐	Difficulty Swallowing
☐	☐	Ulcers
☐	☐	Hiatel Hernia
☐	☐	Indigestion
☐	☐	Nausea / Vomiting
☐	☐	Chrons Disease
☐	☐	Ulcerative Colitis
☐	☐	Irregular Bowel
☐	☐	Diverticulitis
☐	☐	Rectal Bleeding
☐	☐	Hemorrhoids
☐	☐	Diarrhea
☐	☐	Constipation

Female

☐	☐	Pregnancy
☐	☐	Menopause When_____
☐	☐	Last Period ___/___/___
☐	☐	Radiation

Male

☐	☐	Prostate
☐	☐	TURP
☐	☐	Radiation

Personal History Cancer: Type _____

Family History Cancer: Type _____

Patient Signature _____

Filled Out By_____ Relationship _____

Reviewing RN Signature / initials _____