St.JosephHealth
Mission Surgery Center

PRE-OPERATIVE INFORMATION FORM

To our Patients:

Mission Surgery Center welcomes the opportunity to participate in your medical care. This form has been developed to assist you in accurately communicating important medical information to the members of your healthcare team. Please bring this completed form with you when you register at Mission Surgery Center. If you have questions, or wish to discuss any aspect of your care, please do not hesitate to contact us at (949) 364-2201.

PATIENT NAME: _____ AGE:_____ Sex: M F

Please Note:

If you are having any type of anesthesia other than a local injection, an anesthesiologist will be calling you the evening before surgery to review your medical history, provide instructions if necessary, and to answer any questions you may have. ***Please plan to be home the evening prior to your scheduled surgery date to receive this call.*** If you will not be at your home phone number the evening prior to surgery, please enter the number below where you can be reached:[For patients unable to give legal consent, calls will be made to the parent, legal guardian or conservator.]

Alternate Phone Number _____

If you are receiving any type of anesthesia other than a local injection, you must have someone drive you home from the Surgery Center. Patients receiving local anesthetic agents only, and patients undergoing pain management procedures, should follow the instructions of their surgeon or pain management provider regarding driving themselves home.

Please list the name of your driver and a phone number where we may reach the driver following your surgery:

Name:_____ Phone:_____

Someone from our nursing staff will be calling you the day following your surgery (call will be on Monday, if your surgery is on a Friday) to see how you did after surgery. If you will not be recovering at home, please provide the phone number where we may reach you at that time.

Phone Number: _____

May the nurse calling after your surgery speak with anyone other than the patient, (or parent/ guardian/ conservator) about the patient's recovery?

Yes No

Signature of Patient:_____ Date: _____ Time:_____

For Minor Patient: or Patient Unable to Sign:

Patient is Unable to Sign Because: _____

Signature of Parent/Guardian/Conservator: _____ Date: _____ Time:_____

[This form has two sides. Please complete the reverse side of this form.]

PRE-ADMISSION QUESTIONNAIRE

1. Have you ever had any problems with a **heart murmur**, **heart disease**, **palpitations** or **angina**? ☐ Yes ☐ No
   If yes, list. Circle each one that pertains above.
2. Have you ever had **breathing problems**, **asthma**, **hay fever**, **chronic bronchitis**, **emphysema** or **shortness of breath**? (Circle if yes) Do you get short of breath walking up stairs? _____ ☐ Yes ☐ No
3. Have you ever had any seizures, convulsions, migraine headaches, fainting spells or stroke? ____ ☐ Yes ☐ No
4. Do you have high blood pressure? _____ ☐ Yes ☐ No
5. Have you ever had **jaundice**, **hepatitis**, **liver disease** or blood transfusion reactions? (Circle if yes) ☐ Yes ☐ No
6. Do you have diabetes, hypoglycemia or thyroid problems? _____ ☐ Yes ☐ No
7. Do you have kidney problems? _____ ☐ Yes ☐ No
8. Do you have any **physical disabilities**, **back pain**, **numbness** or **weakness of extremities**, **arthritis** or **bursitis**? (Circle if yes) _____ ☐ Yes ☐ No
9. Do you have any bleeding tendencies? _____ ☐ Yes ☐ No
10. Do you ever wake up short of breath? _____ ☐ Yes ☐ No
11. Do you cough excessively? If yes, do you bring up anything when you cough? _____ ☐ Yes ☐ No
12. Have you ever had an abnormal chest x-ray? _____ ☐ Yes ☐ No
13. Have you had significant weight loss over the past several months? _____ ☐ Yes ☐ No
14. Do you have eye problems? _____ ☐ Yes ☐ No
15. Do you wear contact lenses? _____ ☐ Yes ☐ No
16. Do you have any other medical conditions? Please List _____ ☐ Yes ☐ No
    _____
17. Do you have sleep apnea? _____ ☐ Yes ☐ No
18. Have you ever had motion sickness? _____ ☐ Yes ☐ No
19. Have you ever been under the care of a psychiatrist? _____ ☐ Yes ☐ No
20. Have you had a cold, sore throat, or flu in the past two weeks? _____ ☐ Yes ☐ No
21. Within the past two weeks have you had any exposure to chicken pox, mumps, measles, or German measles? _____ ☐ Yes ☐ No
22. Do you have loose or chipped teeth, dentures, bridges, or capped front teeth? _____ ☐ Yes ☐ No
23. Do you have difficulty opening your mouth or keeping it open? _____ ☐ Yes ☐ No
24. Do you smoke? ☐ Yes ☐ No Number of packs per day _____
25. Have you or any blood relative had an unusual reaction to anesthesia or had malignant hyperthermia? ____ ☐ Yes ☐ No
26. Within the past year have you taken or had injections of cortisone or other steroids? _____ ☐ Yes ☐ No
27. Within the past two weeks have you taken a tranquilizer, diet pills or herbal products? _____ ☐ Yes ☐ No
28. Do you take large amounts of vitamins? _____ ☐ Yes ☐ No
29. Have you recently used Aspirin or products containing Aspirin? _____ ☐ Yes ☐ No
30. Do you take blood thinners (Heparin, Coumadin, etc.)? _____ ☐ Yes ☐ No
31. Have you taken any medications today? If yes, list in ***Section B** below: _____ ☐ Yes ☐ No
32. Would you say that you are exceptionally anxious about your pending surgery? _____ ☐ Yes ☐ No
33. Could you be pregnant at this time? _____ ☐ Yes ☐ No
34. Date of last menstrual period (if applicable) _____
35. Previous Operations, Year (if Known) _____
36. Type of anesthesia (general,spinal, epidural, local) _____
37. List any Complications (ex: fever, nausea, vomiting, low blood pressure) _____

Please enter your current: Height:_____ Weight:_____

A. Are you allergic to anything? If yes, please list: _____ ☐ Yes ☐ No
_____
_____

***Section B. Please list all medications you take on a routine basis, including hormones and non-prescription medications:**

_____ _____ _____
_____ _____ _____

C. Circle any of the following pain medications you have taken:

Tylenol Codeine Darvon Percodan Aspirin

List others: _____

Completed By: _____ **Date:** _____ **Time:** _____

Relationship to Patient: _____

Reviewed By: _____ **R.N. Date:** _____ **Time:** _____