PRE-ADMISSION HEALTH QUESTIONNAIRE

Please fill out and hand to the receptionist when completed. The information on this sheet will be discussed with the nurse upon admission.

PATIENT ACCOMPANIMENT UPON DISCHARGE ADVISEMENT

For patient safety, you are hereby advised that it is the policy of Pain Care Providers Surgery Center ("PCPSC") that all patients who receive medical services, requiring anesthesia, be discharged in the company of an adult friend or family member "responsible adult sponsor".

PCPSC will make every attempt to accommodate your scheduled surgery and if you are not willing or able to provide the name and telephone number of a responsible adult sponsor to accompany you home following surgery, your surgery will be rescheduled to another date.

RESPONSIBLE PARTY DE	CONTACT NUMBER(S): 1. 2.										
	Waiting in Lobby: ☐ Yes ☐ No										
I HAVE RECEIVED, READ AND UNDERSTAND THIS PATIENT ACCOMPANIMENT UPON DISCHARGE ADVISEMENT											
PATIENT SIGNATURE:	DATE:		TIME:								
SIGNATURE OF DULY AUTH		IF SIGNED BY OTHER THAN PATIENT, INDICATE RELATIONSHIP:									
PATIENT SELF ASSESSMENT											
ALLERGIES to Drug / Me	Reaction	on:				ALLERGIC T	O LATEX:				
				,					□ Yes □ No		
HEIGHT: WEIGHT(lbs): P			Primary Car	Primary Care Physician or Internist:							
LIST MEDICATIONS YOU TAKE CURRENTLY (including aspirin, natural herb supplements, diet pills):											
LIST MEDICATIONS TO	UTTAK	TO CORRE	AND DESCRIPTION	uding aspirin,	natural nero sup	prements, ar	et pms):	er shaki			
CEE ATTACUMENT FOR MEDICATION LIST											
SEE ATTACHMENT FOR MEDICATION LIST											
		Tr.									
LIST PREVIOUS SURGE	RIES (DR PROCI	EDURES (in	cluding childho	od):						
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PAST OR PRESENT HEALTH HISTORY (CIRCLE YES OR NO)											
Health Issue			Explain	The state of the s	Health Issu	Accessed to the same of the sa	and the last last last last last last last last	SECTION S	F	xplain	
Stroke	Yes	No	Ехріані	Heada		c	Yes	No	E	кріані	
High Blood Pressure	Yes	No			d Disorder		Yes	No			
Smoking: Year Quit:	Yes	No		and the same of th	esis / Pacemaker		Yes	No			
Lung Disease:	Yes	No			A STATE OF THE STA		Yes	No			
Asthma / COPD					A SALS HERE SERVED LEAST SERVED. ACT						
Sleep Apnea-C-Pap	Yes	No		Past A	nesthesia Problems		Yes	No			
Diabetes: Type I or II	Yes	No	Bleeding Disorder				Yes	No			
Heart Disease:	Yes	No		Recent Cold / Flu / Infection				No			
Arrhythmia	-			Date:							
Recent Chest Pain/Heart Pain	Yes	No		Glauce			Yes	No			
Mitral Valve Prolapse	Yes	No		Arthrit	The state of the s	Yes Yes		No No			
Liver Disease Hepatitis	Yes Yes	No No			e Disorders	eflux- GERD		No			
Cancer	Yes	No				Pain: Location		No			
Kidney Disease	Yes	No		Other:			Yes Yes	No			
Immune Deficiency-HIV	Yes	No			t: LMP-Date:			io N/	A		
PATIENT SIGNATURE:				DAT	E:	If signed b	y other th	nan pa	tient, indicate	relationship	
THE STATE OF THE S				1							
By signing below you are st	ating	hat the abo	ve informat	ion has not cha	nged since your	last visit to	PCPSC.	922			
By signing below you are stating that the above information has					OATE: If signed by other than patient, indicate relationship						
PATIENT SIGNATURE:					ь.					Page to the Color Enterthing to 1 € CA	
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PATIENT SIGNATURE:				DAT	E:	If signed by other than patient, indicate relationship					
				8							
		PATIENT LABEL									
		PATIENT LABEL									

PAIN CARE PROVIDERS SURGERY CENTER