# RIVERSIDE SURGICAL CENTER
## Pre-Operative Patient Assessment

| Patients Age (yrs) | Name of driving escort/ relationship | Doctors name: | Procedure type scheduled |
|---|---|---|---|
| | | | |

| Informed of Advance Directive Policy ☐ Yes ☐ No | Last visit date<br>Visit type | Date of last toxicology screen | IV sedation ☐ Yes ☐ No | Oral Sedation ☐ Yes ☐ No |
|---|---|---|---|---|

**ALLERGIES**

| | | | | | | |
|---|---|---|---|---|---|---|
| Any new allergies | ☐ No | ☐ Yes | If Yes, Type: | | Reaction: | |
| Contrast allergy / IVP allergy | ☐ No | ☐ Yes | | | | |
| Iodine allergy | ☐ No | ☐ Yes | Adhesive allergy | ☐ No | ☐ Yes | |
| Betadine allergy | ☐ No | ☐ Yes | Latex allergy | ☐ No | ☐ Yes | |

| **BLOOD THINNERS**<br>Are you currently taking a blood thinner? | No | Yes | Dose | Anti-coag protocol in place? | Date to temp D/C | Last dose | Time of Last dose AM / PM | INR results (if applicable) | Date Of INR |
|---|---|---|---|---|---|---|---|---|---|
| Aspirin 325mg temp, decreased to aspirin 81 mg | ☐ No | ☐ Yes | mg | Yes / No | | | | | |
| Lovenox / Plavix / Adenosine / Effient / Xarelto | ☐ No | ☐ Yes | mg | Yes / No | | | | | |
| Coumadin / Warfarin / Aggrenox | ☐ No | ☐ Yes | mg | Yes / No | | | | | |
| OTC: Ibuprofen / NSAIDS: / Goodys / BC Powder | ☐ No | ☐ Yes | mg | Yes / No | | | | | |
| Do you use recreational and or illegal drugs<br><br>Patient initials: ________________ | ☐ No | ☐ Yes | Comments: | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Current alcohol use | ☐ No | ☐ Yes | Up to: | Drinks Per: | ☐ Former | |
| Reason not pregnant (if female) | ☐ N/A Male | ☐ Hysterectomy | ☐ Postmenopausal | Check if UCG Needed | ☐ Yes | ☐ No |

**CARDIOVASCULAR History**

| | | | |
|---|---|---|---|
| Coronary artery disease / heart disease | ☐ No | ☐ Yes | |
| Chest pain at this time | ☐ No | ☐ Yes | |
| History of heart surgery | ☐ No | ☐ Yes | |
| Heart failure | ☐ No | ☐ Yes | |
| History of blood clots | ☐ No | ☐ Yes | |
| Pacemaker | ☐ No | ☐ Yes | |
| Defibrillator | ☐ No | ☐ Yes | |
| High blood Pressure | ☐ No | ☐ Yes | |
| Other | ☐ No | ☐ Yes | If yes, please explain: |

**PUTLMONARY History**

| | | | | | |
|---|---|---|---|---|---|
| Current respiratory infection | ☐ No | ☐ Yes | | | |
| Shortness of breath | ☐ No | ☐ Yes | | | |
| COPD / Emphysema | ☐ No | ☐ Yes | | | |
| History of Tuberculosis | ☐ No | ☐ Yes | | | |
| Asthma | ☐ No | ☐ Yes | | | |
| Sleep apnea | ☐ No | ☐ Yes | | | |
| Smoker | ☐ No | ☐ Yes | Up to: | Packs Per: | ☐ Former |
| Other | ☐ No | ☐ Yes | If yes, please explain: | | |



ID / Visit: /
,
DOB:
Phys:

DOS: 1/1/0001
Sex:
Age:

| ENDOCRINE History | | | |
|---|---|---|---|
| Diabetes: Type I Type II | ☐ No | ☐ Yes | |
| Hypoglycemia Unspecified | ☐ No | ☐ Yes | |
| Hyperthyroidism | ☐ No | ☐ Yes | |
| Hypothyroidism | ☐ No | ☐ Yes | |
| Other | ☐ No | ☐ Yes | If yes, please explain: |
| **INFECTIOUS DISEASE History** | | | |
| Currently on antibiotics | ☐ No | ☐ Yes | *Describe:* |
| Current fevers, sweats or chills | ☐ No | ☐ Yes | *Describe:* |
| HIV | ☐ No | ☐ Yes | |
| Other | ☐ No | ☐ Yes | If yes, please explain: |
| **GENITOURINARY History** | | | |
| History of kidney failure / Disease | ☐ No | ☐ Yes | |
| Dialysis | ☐ No | ☐ Yes | |
| Kidney stones | ☐ No | ☐ Yes | |
| Other | ☐ No | ☐ Yes | |
| **GASTROINTESTINAL History** | | | |
| History of Hepatitis | ☐ No | ☐ Yes | *Type:* |
| Ulcer disease | ☐ No | ☐ Yes | |
| Gastro-esophageal reflux disease | ☐ No | ☐ Yes | |
| Cirrhosis | ☐ No | ☐ Yes | |
| Constipation | ☐ No | ☐ Yes | |
| Other | ☐ No | ☐ Yes | |
| **NEUROLOGIC History** | | | |
| Seizures | ☐ No | ☐ Yes | |
| Stroke | ☐ No | ☐ Yes | |
| Transient Ischemic Attack(s) | ☐ No | ☐ Yes | |
| Vagal episodes in past | ☐ No | ☐ Yes | |
| Syncope | ☐ No | ☐ Yes | |
| Other | ☐ No | ☐ Yes | If yes, please explain: |
| **SKIN History** | | | |
| Any rashes | ☐ No | ☐ Yes | |
| Skin ulcers or breakdown | ☐ No | ☐ Yes | |
| Shingles | ☐ No | ☐ Yes | |
| Other | ☐ No | ☐ Yes | |
| **MALIGNANCY History** | | | |
| History of cancer | ☐ No | ☐ Yes | *Type:* *Treament:* |

Signature of Patient: ______________________ Date: ________________ Time: ____________

Signature of Reviewer: ______________________ Date: ________________ Time: ____________

Signature of Nurse: ______________________ Date: ________________ Time: ____________

Signature of Physician: ______________________ Date: ________________ Time: ____________



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,
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