NORTHERN CALIFORNIA
Advanced Surgery Center, LP

Patient's Assessment and History Form

Patient name: ______________________________ DOB: ____________________

My primary care physician is: ____

Located at: ____

Phone number: ________________________ Fax (if available): ________________

INSTRUCTIONS: Please provide information on any past or current medical conditions you may have. If there are multiple conditions listed within the line, please circle all that apply.

FAMILY HISTORY:

Have there been any **family history** of problems with anesthesia: ☐ Yes ☐ No
If yes, please describe (nausea, vomiting, difficult to wake up, high fevers). ________________________

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COMPREHENSIVE MEDICAL HISTORY:

☐ I have never been diagnosed with any medical issues.

Disease	Positive	Pertinent Neg	Comment/Description/Pertinent Data
High Blood Pressure	☐	☐	☐ Controlled
Diabetes	☐	☐	☐ Insulin
Kidney Disease	☐	☐	☐ Dialysis /Schedule
Abnormal Heart Rhythm	☐	☐	☐ Type
Heart attack or Chest pain (circle one or both)	☐	☐	☐ When, Intervention
Stroke	☐	☐	☐ When, Intervention
Blood Thinners	☐	☐	☐ Drug(s)
Reflux	☐	☐	
Asthma/COPD	☐	☐	
Sleep Apnea	☐	☐	☐ CPAP
Arthritis	☐	☐	
Hepatitis	☐	☐	☐ Type
Prostate	☐	☐	☐ Drug
Thyroid	☐	☐	☐ Type

(continued on reverse)

Disease	Positive	Pertinent Neg	Comment/Description/Pertinent Data
Other	☐	☐	
Head/Neck	☐	☐	
Heart	☐	☐	
Lungs	☐	☐	
Abdominal	☐	☐	
Stomach, Bowel, Liver, Gallbladder, or Pancreas	☐	☐	
Bladder or Prostate	☐	☐	
Clotting or Bleeding Disorders	☐	☐	
Hormone or Gland Disorders	☐	☐	
Orthopedics	☐	☐	
Vessel Disorders	☐	☐	
Brain Disorders	☐	☐	
Cancer			

Are you currently being treated for vancomycin resistant enterococci (VRE) or methacillin resistant staphylococcus aureus (MRSA)? ☐ **Yes** ☐ **No**

If yes, how long have you been on antibiotics? ______________________________

Allergies:

	Yes	No
Latex/Rubber	☐	☐
Dyes/Tape	☐	☐
Shellfish/Seafood	☐	☐
Medications Allergies:	**List Reaction below**	

Past Surgical History:

Year	Procedure

FOR STAFF USE

______________________ Reviewed By ______________ Date ________ Time