KANSAS SURGERY & RECOVERY CENTER

2770 N. Webb Rd. Wichita, KS 67226 (316) 634-0090

PATIENT NAME (LAST)	(FIRST)	(MIDDLE INIT.)

SEX ❑ MALE ❑ FEMALE	AGE	HEIGHT	WEIGHT

Have you ever been diagnosed with or had any of the following: *(Please check yes or no)*

Sinusitis	❑ Yes	❑ No	AIDS/HIV	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Kidney Failure/Dialysis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Thyroid Disorders	❑ Yes	❑ No
Pneumonia	❑ Yes	❑ No	Bladder Disorders/Difficulty/Frequency	❑ Yes	❑ No
Bronchitis	❑ Yes	❑ No	Stomach Disorders	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Bowel Disorders	❑ Yes	❑ No
Blood Clot(s)	❑ Yes	❑ No	Tremors (Parkinson's)	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Convulsions/Epilepsy	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No	CVA/Stroke	❑ Yes	❑ No
Jaundice	❑ Yes	❑ No	Fainting Episodes	❑ Yes	❑ No
Sickle Cell	❑ Yes	❑ No	Bleeding Disorders	❑ Yes	❑ No
MRSA Infection	❑ Yes	❑ No	C.diff infection	❑ Yes	❑ No

Do you smoke? ❑ Yes ❑ No How much? _____

Have you ever smoked? ❑ Yes ❑ No

Did you quit? ❑ Yes ❑ No How long ago? _____

Do you suffer from a chronic cough? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No

SKIN ASSESSMENT

Do you have any reddened or open areas on your operative extremity?
❑ Yes ❑ No If yes, where? _____

Do you have any reddened or open areas anywhere on your body?
❑ Yes ❑ No If yes, where? _____

CARDIOVASCULAR HISTORY

Do you have high blood pressure?	❑ Yes	❑ No
Have you ever had a heart attack?	❑ Yes	❑ No
Do you have palpitations?	❑ Yes	❑ No
Do you have irregular heartbeat?	❑ Yes	❑ No
Do you have fast heart beat?	❑ Yes	❑ No
Do you have a heart murmur?	❑ Yes	❑ No
Do you suffer from angina/chest pains?	❑ Yes	❑ No
Do you have any heart disease?	❑ Yes	❑ No
Do you have a cardiac pacemaker?	❑ Yes	❑ No

MEDICAL HISTORY

Do you have sleep apnea?	❑ Yes	❑ No
Do you have a history of depression?	❑ Yes	❑ No
Have you had a recent cold?	❑ Yes	❑ No
Are you hard of hearing?	❑ Yes	❑ No
Are you pregnant or could you be?	❑ Yes	❑ No
Do you have diabetes?	❑ Yes	❑ No

❑ Type I or ❑ Type II

❑ Diet controlled ❑ Oral medications ❑ Insulin

PLEASE LIST OTHER MEDICAL HISTORY

_____

_____

_____

HAVE YOU BEEN HOSPITALIZED IN THE PAST 6 MONTHS FOR: (IF YES, PLEASE CHECK THE FOLLOWING BOXES BELOW)

☐ HEART ATTACK (MI) ☐ BLOOD CLOTS IN LEGS (DVT), OR LUNGS (PE) ☐ STROKE

_____

_____

PLEASE LIST FAMILY MEDICAL HISTORY

_____

_____

PLEASE LIST ALL PREVIOUS SURGERIES

_____

FOR ANESTHESIA USE ONLY

Notes: _____

Anesthesia Plan: ❑ General ❑ Regional ❑ Monitored Anesthesia Plan ❑ Local Only _____

Physician Signature: _____ Date/Time: _____ _____

PATIENT SIGNATURE	DATE

PRE-OP RECORDS **PATIENT HISTORY**