Ambulatory Surgery Center of Niagara
6500 Porter Road, Suite 2030
Niagara Falls, NY 14304
Phone: 716-285-2020 Fax: 716-285-2060

Patients Label

Personal Health History / Patient Self-Assessment
PLEASE COMPLETE & RETURN PROMPTLY

Patient Name	**Date of Birth**
Phone Number and best time to reach you:	
Date of surgery:	**Surgeon:**
What procedure/site are you scheduled for?	**Primary Medical Doctor: _____** **Dr. Telephone Number: _____** **Date of Appointment for Surgical Clearance: _____** ***Please schedule appointment at least 5 days prior to procedure.**
What is your Primary Language □ English □ Other: ***If you need a hearing or language interpreter, please call our office at 285-2020 (1) week in advance.***	
Height _____ Weight _____ **Are you Diabetic? _____** **Do you use Insulin? _____**	**Are you allergic to Latex (rubber)?** ☐ No ☐ Yes ***If yes, please describe reaction:*** ***Please call the Surgery Center (285-2020) if you responded YES to this question. If necessary, we will develop a special plan of care for you.***
Do you have any of the following conditions? **Check all that apply**	**Do you have any open wounds on your body?** ☐ No ☐ Yes ***If YES, explain***:
☐ Breathing Problems ☐ Asthma ☐ Emphysema ☐ shortness of breath ☐ COPD ☐ Other **Do you wear oxygen?** ☐ No ☐ Yes Explain: **Do you have Sleep Apnea?** ☐ No ☐ Yes **Do you use a CPAP machine?** ☐ No☐ Yes ☐ Heart Problems: ☐ Chest pain / angina ☐ Circulatory Problems ☐ High Blood Pressure ☐ History of Strokes: _____ ☐ Previous M.I. (heart attack): _____ ☐ I have an implantable defibrillator / ICD ☐ I have a Cardiac Pacemaker ☐ Bleeding Problems ☐ Other: ☐ Seizure Disorder: Date of last seizure: _____ ☐ Arthritis: ☐ Gastro-intestinal Problems ☐ Hiatal Hernia ☐ Difficulty Swallowing ☐ GERD (Reflux) ☐ Other: ☐ Cancer: ☐ Kidney Disease ☐ Dialysis / schedule: _____ ☐ Hepatitis ☐ Other: _____ ***Females Only***: **Could you be pregnant?** ☐ No ☐ Yes **Are you Post-Menopausal?** ☐ No ☐ Yes **Have you had a Hysterectomy?** ☐ No ☐ Yes	**Do you take aspirin or blood thinners?** ☐ No ☐ Yes /name: _____ **Have you been instructed to stop your blood thinners prior to surgery**? ☐ No ☐ Yes ***If YES, when was your last dose?*** **_____** **Do you need any assistance with walking**? ☐ No ☐ Yes **Do you use a:** ☐ Walker ☐ Wheelchair ☐ Cane **Have you had a fall within the last year**? ☐ No ☐ Yes **Did you sustain any fracture from this fall?** ☐ No ☐ Yes **Have you been out of the country in the last 6 months? _____** **If yes, where did you go? _____** **Were you sick upon return?** ☐ No ☐ Yes **Have you ever had surgery before?** ☐ No ☐ Yes ***If Yes list surgery/ dates:*** **_____** _____ **Have you or any members of your family had any problems connected with anesthesia?** ☐ No ☐ Yes ***If YES, explain:*** **_____** ***Please Continue on Back of Form**

Have you recently been ill with a cold, fever or flu? ☐ No ☐ Yes

Have you been hospitalized for any reason in the past year? ☐ No ☐ Yes
If YES, please specify:

Do you drink alcohol daily? ☐ No ☐ Yes ***If YES, how much***?

Do you smoke cigarettes? ☐ No ☐ Yes ***If YES, how much?***

Do you use recreational drugs? ☐ No ☐ Yes ***If YES, explain***

Do you have transportation on the day of your surgery? ☐ Yes ☐ No
****If NO, please contact the surgery center as soon as possible***

Signature of Patient (*or Responsible Adult*) completing form: _____

If not completed by patient, this form was completed by: ☐ Relative ☐ Friend ☐ Other
Reason*:*

Relationship: Daytime Phone Number:

If this patient is unable to sign for him/herself, do they have a Healthcare / Medical POA responsible for patient consent?

(*Name of person*) _____

Relationship: _____ Daytime Phone Number: _____

▼ Surgery Center Use ▼

☐ Local no testing required

☐ **Nursing Review / Signature: _____ Date: _____**

Notes:

Discharge Reminder:

Following your surgery, you may need someone available at home to help you with your care.