Patient Name:
DOB:
Physician:
Procedure Date:

Memorial Care Outpatient Surgical Center Long Beach

Height: **Weight:** **Procedure:**

Pre-Assessment Survey

*** 1. What is your date of birth?**

____ / ____ / ________

*** 2. What is your height?**

____

*** 3. What is your current weight?**

____

*** 4. Is your BMI (Body Mass Index) above 45 or weigh greater than 350lbs?**

○ Yes ○ No ○ Unsure

*** 5. What is your sex?**

○ Male ○ Female ○ Other

*** 6. Is English your primary language?**

○ Yes ○ No

If no, please specify your primary language

____

____

____

*** 7. Who is driving you home?**

Name: ______________________________

Phone Number: ______________________________

*** 8. Have you had a fever of 100 degrees or above in the last 2 weeks?**

○ No ○ Yes

*** 9. Have you experienced any of the following in the last 2 weeks? Please check all that apply.**

	Please check all that apply	Explanation
	Cough	
	Shortness of Breath	
	Sore Throat	
	None of the Above	

*** 10. Have you had a laboratory confirmed diagnosis of COVID-19 in the last 4 weeks?**

○ No ○ Yes

*** 11. Do you have any allergies to medications, food, or latex?**

○ No ○ Yes

If yes, please specify

____

____

____

*** 12. Do you drink alcohol?**

○ No ○ Yes

12A. How many drinks do you have per week (example: 1 drink per week)?

____

*** 13. Do you smoke or use any tobacco/nicotine products?**

○ No ○ Yes

13A. How much do you smoke per day (example: 1 pack per day)?

____

*** 14. Are you a former smoker?**

○ No ○ Yes

If yes, please specify pack per years:

____

____

____

*** 15. Do you use any recreational drugs including marijuana?**

○ No ○ Yes

15A. If yes, what drug, how often, and when was the last time you took it?

____

*** 16. Do you take any prescription drugs or over the counter (e.g., aspirin) medications?**

○ No ○ Yes

*** 16A. What is the drug name, dose, frequency, date last taken and purpose? Please include all blood thinners, herbal supplements, diet pills and inhalers. *If you prefer to bring a physical copy of your medication list, please type, " I WILL BRING MEDICATION LIST"**

	Medication Name	Dosage	Frequency	Date Last Taken	Purpose
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

This question requires an answer.

17. Are you currently taking any GLP-1 Agonist such as Ozempic, Wegovy (semagluide), Trulicity, and Rybelsus? If answer is yes, please contact your physician to determine your last dose prior to your procedure.

○ Yes ○ No

*** 18. Do you have Sleep Apnea?**

○ No ○ Yes

*** 19. Have you had any past surgeries or procedures that required anesthesia? Please list (up to five most recent) surgeries with date and type of anesthesia provided or put "N/A" if not applicable.**

	Procedure, Anesthesia Type, and Date
1	
2	
3	
4	
5	

This question requires an answer.

*** 20. Anesthesia History: Please check all that apply.**

	Please check all that apply	Explanation
	Bad Reaction to Anesthetics	
	Relatives with Bad Reactions to Anesthetics	
	Problems with Motion Sickness	
	Malignant Hyperthermia in Patient or Relatives	
	None of the Above	

*** 21. Cardiovascular History: Do you have any of the following conditions? Please check all that apply.**

	Please check all that apply	Explanation
	Irregular Heartbeat	
	Coronary Artery Disease (CAD)	
	Heart-Related Chest Pain (Angina)	
	Heart Attack	
	High Blood Pressure	
	Congestive Heart Failure (CHF)	
	Abnormal Electrocardiogram	
	Other	
	None of the Above	

*** 22. Pulmonary (Lung) History: Do you have any of the following? Please check all that apply.**

	Please check all that apply	Explanation
	Recent Cold, Cough, or Sore Throat	
	Asthma	
	Emphysema/COPD	
	Bronchitis, or Breathing Problems	
	Abnormal Chest X-Ray	
	Home Oxygen Use	
	Tuberculosis (TB)	
	Other	
	None of the Above	

*** 23. Renal (Kidney) History: Do you have any of the following conditions? Please check all that apply.**

	Please check all that apply	Explanation
	Kidney Failure	
	Kidney Stones	
	Bladder/Urinary Incontinence	
	Prostate Trouble	
	Other	
	None of the Above	

*** 24. Hepatic (Liver) History: Do you have any of the following conditions? Please check all that apply.**

	Please check all that apply	Explanation
	Cirrhosis	
	Liver Failure or Yellow Jaundice	
	Hepatitis (Please indicate type below)	
	Other	
	None of the Above	

*** 25. Gastrointestinal (GI) History: Do you have any of the following conditions? Please check all that apply.**

	Please check all that apply	Explanation
	Frequent Acid Reflux or Heartburn	
	Diarrhea	
	Diverticulitis	
	Other	
	None of the Above	

*** 26. Neurological History: Do you have any of the following conditions? Please check all that apply.**

	Please check all that apply	Explanation
	Epilepsy or Seizures	
	Stroke, Numbness, or Weakness	
	Frequent Migraines that Require Treatment	
	Other	
	None of the Above	

*** 27. Endocrine History: Do you have any of the following conditions? Please check all that apply.**

	Please check all that apply	Explanation
	Diabetes Type 1	
	Diabetes Type 2	
	Abnormal Bleeding	
	Other	
	None of the Above	

*** 28. Do you or have you ever had cancer?**

○ No ○ Yes

If yes, please specify

____

____

____

Memorial Care Outpatient Surgical Center Long Beach

HST Case Coordination™

29. Do you have any of the following conditions? Please check all that apply.

	Please check all that apply	Explanation
	ORSA	
	C-diff (Clostridium Difficile)	
	VRE (Vancomycin-Resistant Enterococcus)	
	MRSA	
	Shingles (current or within the last 6 months)	
	Other	
	None of the above	

*** 30. 32. Hematologic (Blood) History: Do you have any of the following conditions?**

	Please check all that apply	Explanation
	HIV or AIDS	
	Anemia	
	Bleeding or Blood Clotting Disorders	
	Other	
	None of the Above	

*** 31. Have you fallen in the last 6 months?**

○ No ○ Yes

*** 32. Do you require assistive devices (i.e., cane, walker, wheelchair)?**

○ No ○ Yes

If yes, please specify

____

____

____

*** 33. Do you require assistance with walking, or transferring to a chair/bed?**

○ No ○ Yes

If yes, please specify

____

____

____

*** 34. Do you have vision problems that affect your mobility?**

○ No ○ Yes

*** 35. Do have hearing problems that affect your mobility?**

○ No ○ Yes

36. DO NOT COMPLETE- For Office Use Only

	Signature
Pre-Op RN- Date/Time	
Intra-Procedure RN- Date/Time	
PACU RN- Date/Time	

ADDITIONAL INFORMATION: ______________________________

____

____

____