

EAST TENNESSEE AMBULATORY SURGERY CENTER, LLC 701 Med Tech Parkway Johnson City Tennessee 37604 Phone - 423-283-7302 Fax – 423-282-3670	Patient Label
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Pre-Admission Part I

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	Procedure:
Date of Birth:	
Name of person accompanying you on date of surgery?	Surgeon:
Phone:	

PERSONAL HEALTH HISTORY

Previous Anesthesia Problems or Complications: (for you or any blood relative)	<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Difficult Airway/Breathing <input type="checkbox"/> Malignant Hyperthermia procedure <input type="checkbox"/> Prolonged hospital/surgery stay <input type="checkbox"/> Other:	<input type="checkbox"/> High Fever <input type="checkbox"/> Prolonged weakness <input type="checkbox"/> Difficulty awakening after
<input type="checkbox"/> Never had anesthesia <input type="checkbox"/> No problems with anesthesia		

Physicians: (List all of your personal physicians including Primary Care, Cardiology, Neurology, Pain Management, Orthopaedic, etc.)

Physician Name	Address/City, State	Phone	Last Visit

Patient or Family History: *Muscle Weakness, Atrophy, or disease such as Myotonia or Dystrophy?* Yes No

Have you ever had a blood transfusion? Yes, Year _____ No

Any transfusion reaction or problem? Yes, Describe _____ No

Any urinary tract, bladder, or kidney infections within the last year? Yes Date: _____ No

WOMEN ONLY

Date of last menstrual period: _____ Period every ____ days Regular Irregular

Is there any chance you could be pregnant? Yes No

Form Completed by: _____ Date: _____

Relationship to Patient if other than self: _____