



SAME DAY SURGICAL FORM

Yes	No	SOCIAL HISTORY	
		Do you use alcohol? # Drinks/Day:	
		Do you use tobacco? Type: Amount daily: Years:	
		Do you use street drugs? Last Use: Type:	
		Do you wear glasses/contacts? Hearing aids? Dentures? Partials? Upper Lower	
		Are you on a special/prescribed diet? Describe:	
		Do you have religious or cultural practices that may affect your medical care:	
		Describe:	

Yes	No	MEDICAL HISTORY	COMMENTS	ALLERGIES			
		Anesthesia Problems		(FOOD, DRUG, LATEX)	REACTIONS		
		Heart Problems					
		High Blood Pressure					
		GI Problems/Hiatal Hernia					
		Hepatitis/Yellow Jaundice		MEDICATIONS			
		Convulsions/Fits		NAME / DOSE	Schedule	Last Taken	
		Cstroke					
		Thyroid Condition					
		Arthritis					
		Cancer					
		Diabetes					
		Bleeding Disorder					
		Emotional Problems					
		Tuberculosis					
		Kidney/Bladder Problems					
		Muscle or Nerve Disease					
		Muscle Weakness/Paralysis		IV Time	Site	Needle size	Attempts
		Recent Cold or Flu		Time	Solution		Rate
		Previous Surgeries:					
		Other:		Time	D/C	Cath intact	

Procedure:	Ht	PRE- OP CHECKLIST		N/A	Yes	No
Last Intake:	Wt	Surgical consent signed				
T P R	O2 Sat	Lab work completed				
BP	Pain	History and physical				
Level of Consciousness		Previous records				
Info collected/reviewed by:	Date	Time	Jewelry removed/taped			
			Pre-op teaching			