SURGICARE OF JACKSON
an affiliate of SCA

Patient Medical Information Form

NAME_____ Cell phone:_____ Date of Birth_____

Name of person driving you home_____Relation_____

Driver cell phone number _____ Alternate phone number_____

Email address: _____

PLEASE REMOVE <u>ALL JEWELRY</u> and give to family/friends prior to being called back to pre-op

<u>PLEASE ANSWER ALL QUESTIONS COMPLETELY</u>

When was the last time you had anything to eat or drink? Date_____ Time_____

Do you currently smoke cigarettes? Yes_____ No_____ If yes, how many packs per day?_____

When was your last menstrual cycle? _____ N/A_____ Have you had a hysterectomy? Yes_____ No_____

Who is your primary care provider or regular doctor? _____

Do you currently have or have you ever had any of the following:

	YES	NO	
History of blood clots/Varicose Veins			
Diabetes			
High Blood Pressure			
Heart Problems (heart attack, pacemaker, CHF)			
Sickle Cell anemia/disease			
Lung Problems (asthmas/ COPD/ emphysema)			
Sleep Apnea- Do you use a CPAP machine? Yes or No			
Neurological Problems (stroke, TIAs)			
Seizures			
Stomach problems (ulcers, acid reflux)			
Kidney problems (dialysis)			
Thyroid problems			
Hepatitis of any form			
Meningitis			
Tuberculosis			
Autoimmune disorder (lupus)			
HIV (Aids)			
Cancer of any type			
History of staph infection			
Open and/or weeping wounds – active Shingles/Poison Ivy			
History of MRSA			
Carrier or host of MRSA			
Active MRSA- If yes, are you receiving treatment? Y or N			

If the answer is YES to any of the above conditions, please explain below:

_____

_____

_____

I hereby certify that I have answered the above questions to the best of my knowledge, and have not purposefully withheld information or given false information.

PATIENT/ SURROGANT SIGNATURE_____DATE_____

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PLEASE *PRINT* A COMPLETE LIST OF CURRENT MEDICATIONS

( ) NO MEDICATIONS

MEDICATION	DOSE	HOW OFTEN	LAST TAKEN (TIME)	COMMENTS

Are you currently taking birth control pills? ☐ YES ☐NO ☐N/A

Do have any *ALLERGIES* to medications? ☐ YES ☐ NO KNOWN ALLERGIES

If YES, please LIST allergies and reactions:

_____

_____

BELOW IS CENTER USE ONLY

DISCHARGE PRESCRIPTIONS PROVIDED BY YOUR SURGEON:

☐ No prescription(s) given

MEDICATIONS	DOSE	FREQUENCY	REASON TAKING

☐ You may start your oral pain medication as soon as needed at home.

☐ You have been given a dose of pain medication & may take your next dose at _____, if needed.

RN Signature:_____

☐ May resume ALL home meds. ☐ May resume all home meds EXCEPT _____

Reviewed by Physician:

_____