TEXAS PRECISION SURGERY CENTER

LASER PRE-OPERATIVE ASSESSMENT AND CALL RECORD

PATIENT NAME: **Sex: Male or Female (circle)**	**CONTACT INFORMATION**: best phone # to reach patient Phone #:_________________________ type:_____________ Alternate #:_______________________ type:_____________
DATE OF SURGERY:	Scheduled Arrival Time:

Physician:	Height:	Weight:	BMI:
Scheduled Procedure:			
Birthdate: Age:	Patient has received a copy of the Patient Rights: ☐Yes ☐No	Patient has Advanced Directives: ☐Yes ☐No	
CURRENT MEDICATIONS AND ALLERGIES-- **REFER TO MEDICATION RECONCILIATION LIST**			

PAST MEDICAL HISTORY	**Y**	**N**	**PAST MEDICAL HISTORY**	**Y**	**N**
Heart Attack			Vision Disorder Glaucoma Blind		
Hypertension			Hearing Loss		
MVP Heart Murmur Heart Valve Replacement			Physical Limitations		
Palpitations Irregular heart beat			Last Menstrual Period		
Pacemaker AICD			Alcohol use Amt./day:		
Chest Pain Angina			Smoking history: # of Years: PPD:		
Asthma Bronchitis SOB Home O_2			Recreational drugs		
Sleep Apnea ☐Yes ☐No CPAP ☐Yes ☐No			Pain-*if yes*, location and severity:		
GERD/ Gastrointestinal Disorder			Psychiatric Disorder		
Stroke			Anesthesia History: List any prior complaints		
Seizure Disorder			for yourself or family		
Diabetes type: ☐I ☐ II Hypoglycemia			Other Medical Problems:		
Thyroid Disorder					
Bleeding Disorder Blood Clots			**PAST SURGERIES**	**DATE**	
Kidney Disorder Patient on Dialysis: how often?					
Hepatitis Liver Disorder					

PRE-OP INSTRUCTION GIVEN		
☐Directions to facility	☐Day of surgery instructions given	Notes:
☐Bring insurance card/photo ID / Med. list	Person Interviewed:	
☐Remove contacts / bring glasses		
☐Escort will remain @ facility		

RN/LVN Signature:	Date:	Time:

Texas Precision Surgery Center

5721 Esplanade Drive, Suite A

Corpus Christi, Texas, 78414

Patient label

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MEDICATION RECONCILIATION LIST

******PLEASE FILL OUT INFORMATION BELOW******

Completed By: ______________________________ Date: _______________ Source(s): □ PT □ Family □ MD □ H&P

Name of Pharmacy Used: Primary Care Physician:

Medication Allergies □ NKDA □ Allergy/Reaction

Current Medications

Medication Name Include vitamins & herbal supplements	**Dose** Example: mg, units	**Route** By Mouth Unless Otherwise Indicated.	**How Often** Example: daily, twice a day, As needed	**Discontinued**	**Taken Day of Surgery**
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No

□ Resume All medications as previously prescribed.
Do NOT resume blood thinners until instructed by your physician

Medication Lists Reviewed with each Admission

ASC USE ONLY				
	Med list reviewed with Patient	□ Yes □ No	Date	By:
	Med list reviewed with Patient	□ Yes □ No	Date	By:
	Med list reviewed with Patient	□ Yes □ No	Date	By:
	Med list reviewed with Patient	□ Yes □ No	Date	By:

Patient Name Sticker