Please answer the following questions to the best of your knowledge.

| | | |
|---|---|---|
| **What is your most recent height & weight** | Height: _____ ft. _____ in. | Weight: _____lbs |
| **(Females age 18 to 59) have you had a period in the last year?** | ❑ Yes ❑ No<br>If no, please explain why _____<br>Example: on birth control, hysterectomy, ablation, menopause etc. | |

**Are you allergic to any medications, foods, latex or IV contrast? (please give allergy and reaction to each allergy)**
**Example: Penicillin – hives**

| I AM ALLERGIC TO | MY REACTION TO ALLERGY LISTED | I AM ALLERGIC TO | MY REACTION TO ALLERGY LISTED |
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**Do you have or have you ever had any of the following: (please answer yes or no)**

| PROBLEM | YES OR NO | FOLLOW-UP QUESTION (IF YOU ANSWERED YES) |
|---|---|---|
| **Cardio/Vascular** | | |
| **Chest pain** | ❑ Yes ❑ No | When was your last episode: |
| **Cardiac disease, Coronary Artery Disease** | ❑ Yes ❑ No | Date of diagnosis: |
| **Congestive heart failure** | ❑ Yes ❑ No | Date of diagnosis: |
| **Blood clot** | ❑ Yes ❑ No | Date of diagnosis: |
| **Blood clot in your lungs** | ❑ Yes ❑ No | Date of diagnosis: |
| **High blood pressure** | ❑ Yes ❑ No | |
| **High cholesterol** | ❑ Yes ❑ No | |
| **Heart attack** | ❑ Yes ❑ No | Date of heart attack: |
| **Stents placed in your heart** | ❑ Yes ❑ No | Date stents were placed: |
| **Abnormal heart rhythm** | ❑ Yes ❑ No | Type of abnormal rhythm: |
| **Pacemaker implanted** | ❑ Yes ❑ No | Date pacemaker was placed: |
| **Defibrillator implanted** | ❑ Yes ❑ No | Date defibrillator was placed: |
| **POTS (postural orthostatic tachycardia syndrome)** | ❑ Yes ❑ No | |
| **Raynaud's syndrome** | ❑ Yes ❑ No | |
| **Congenital Heart Defects** | ❑ Yes ❑ No | |
| **Heart Murmur** | ❑ Yes ❑ No | Date of diagnosis: |
| **Any other heart problems** | ❑ Yes ❑ No | Explain: |
| **Respiratory** | | |
| **Asthma** | ❑ Yes ❑ No | |
| **COPD (Chronic obstructive pulmonary disease)** | ❑ Yes ❑ No | |
| **OSA (Obstructive sleep apnea)** | ❑ Yes ❑ No | Do you use a CPAP machine: |
| **If no to OSA, please answer the following questions:** | | |
| **Do you snore loudly?** | | ❑ Yes ❑ No |
| **Do you often feel tired, fatigued, or sleepy during the daytime even after a good night's rest?** | | ❑ Yes ❑ No |
| **Has anyone ever told you that you stop breathing while you are sleeping?** | | ❑ Yes ❑ No |
| **Cystic fibrosis** | ❑ Yes ❑ No | |
| **Use oxygen at home** | ❑ Yes ❑ No | How many liters: |
| **Bronchitis in the last 3 months** | ❑ Yes ❑ No | Date of diagnosis:<br>Did you complete your antibiotics (if applicable): |
| **Pneumonia in the last 3 months** | ❑ Yes ❑ No | Date of Diagnosis:<br>Did you complete your antibiotics (if applicable): |

| | | |
|---|---|---|
| **Respiratory infections in the last 3 months** | ❑ Yes ❑ No | Date of Diagnosis:<br>Did you complete your antibiotics (if applicable): |
| **Other/Notes:** | | |
| **Neurology/Musculoskeletal/Developmental/Mental** | | |
| **Seizure** | ❑ Yes ❑ No | Last episode: Reason for seizure: |
| **Epilepsy** | ❑ Yes ❑ No | Last episode: |
| **Parkinson's** | ❑ Yes ❑ No | Date of Diagnosis: |
| **Stroke** | ❑ Yes ❑ No | Date of Diagnosis: |
| **Mini stroke** | ❑ Yes ❑ No | Date of Diagnosis: |
| **Fainting** | ❑ Yes ❑ No | Last fainting episode: |
| **Dizziness** | ❑ Yes ❑ No | Last dizzy episode: |
| **Migraines or chronic headaches** | ❑ Yes ❑ No | |
| **Neuropathy** | ❑ Yes ❑ No | Where is your neuropathy located: |
| **MS (Multiple sclerosis)** | ❑ Yes ❑ No | Date of Diagnosis: |
| **Weakness** | ❑ Yes ❑ No | Location of weakness: |
| **Fibromyalgia** | ❑ Yes ❑ No | |
| **Arthritis** | ❑ Yes ❑ No | |
| **Hydrocephalus** | ❑ Yes ❑ No | |
| **Abnormal brain development/delay** | ❑ Yes ❑ No | Explain: |
| **Autism** | ❑ Yes ❑ No | |
| **Cognitive Disorder** | ❑ Yes ❑ No | Explain: |
| **Anxiety** | ❑ Yes ❑ No | |
| **Depression** | ❑ Yes ❑ No | |
| **PTSD** | ❑ Yes ❑ No | Are there any triggers we should be aware of: |
| **OCD(Obsessive-compulsive disorder)** | ❑ Yes ❑ No | |
| **ADHD (Attention-deficit/hyperactivity disorder)** | ❑ Yes ❑ No | |
| **Bipolar** | ❑ Yes ❑ No | |
| **Schizophrenia** | ❑ Yes ❑ No | |
| **Dementia/Alzheimer's** | ❑ Yes ❑ No | |
| **Other/Notes:** | | |
| **Gastro/ Hepatic** | | |
| **Heartburn/Acid Reflux/GERD** | ❑ Yes ❑ No | |
| **Ulcers** | ❑ Yes ❑ No | |
| **IBS (Irritable bowel syndrome)** | ❑ Yes ❑ No | |
| **Crohn's / Colitis** | ❑ Yes ❑ No | |
| **Hernia** | ❑ Yes ❑ No | Type: ❑ Repaired ❑ Not Repaired |
| **Constipation** | ❑ Yes ❑ No | |
| **Liver Disease** | ❑ Yes ❑ No | Type of liver disease: |
| **Hepatitis** | ❑ Yes ❑ No | |
| **Other/Notes:** | | |
| **Urinary / Endo** | | |
| **Kidney disease** | ❑ Yes ❑ No | What stage: |
| **Kidney stones** | ❑ Yes ❑ No | Date of Diagnosis: ❑ Passed ❑ Still present |
| **Dialysis** | ❑ Yes ❑ No | |
| **Incontinence** | ❑ Yes ❑ No | |
| **Overactive bladder** | ❑ Yes ❑ No | |
| **Diabetes type 1** | ❑ Yes ❑ No | |
| **Diabetes type 2** | ❑ Yes ❑ No | |
| **Prediabetes** | ❑ Yes ❑ No | |
| **Hyperthyroidism/Graves (over active thyroid)** | ❑ Yes ❑ No | |
| **Hypothyroidism/ Addisons (under active thyroid)** | ❑ Yes ❑ No | |
| **BPH or other Prostate issues** | ❑ Yes ❑ No | |
| **Other/Notes:** | | |
| **Hematology** | | |

| | | |
|---|---|---|
| **Anemia** | ❑ Yes ❑ No | |
| **Sickle Cell** | ❑ Yes ❑ No | |
| **Hemophilia** | ❑ Yes ❑ No | |
| **Factor V** | ❑ Yes ❑ No | |
| **Any other blood clotting disorders** | ❑ Yes ❑ No | Type of disorder: |
| **Taking blood thinners** | ❑ Yes ❑ No | (record on med list) |
| **Other/Notes:** | | |
| **Oncology / Autoimmune** | | |
| **Lupus** | ❑ Yes ❑ No | Date of Diagnosis: |
| **RA (Rheumatoid Arthritis)** | ❑ Yes ❑ No | Date of Diagnosis: |
| **Any type of Cancer** | ❑ Yes ❑ No | Type of Cancer: Date of diagnosis:<br>❑Active ❑In Remission ❑Removed Currently undergoing chemotherapy: ❑ Yes ❑ No |
| **Other/Notes:** | | |
| **Infectious Disease** | | |
| **TB (Tuberculosis)** | ❑ Yes ❑ No | Date of Diagnosis:<br>Was it treated: |
| **HIV/AIDS** | ❑ Yes ❑ No | |
| **MRSA/MSSA (Methicillin-resistant/Susceptible Staphylococcus aureus)** | ❑ Yes ❑ No | Location:<br>Date of Diagnosis:<br>Was it treated: |
| **VRE (Vancomycin-resistant Enterococci)** | ❑ Yes ❑ No | Date of Diagnosis:<br>Was it treated: |
| **STD/STI (only if GYN procedure)** | ❑ Yes ❑ No | Type: |
| **COVID symptoms or Exposure to COVID within 10 days** | ❑ Yes ❑ No | |
| **Infection of any other kind in the last 3 months** | ❑ Yes ❑ No | Type of infection:<br>Was it treated:<br>Are you currently on antibiotics: |
| **Other/Notes:** | | |
| **Eyes, ENT, Dental** | | |
| **Glaucoma** | ❑ Yes ❑ No | |
| **Cataracts** | ❑ Yes ❑ No | |
| **Wear glasses** | ❑ Yes ❑ No | |
| **Wear contacts** | ❑ Yes ❑ No | |
| **Wear hearing aids** | ❑ Yes ❑ No | Left, right or both: |
| **Loose teeth** | ❑ Yes ❑ No | |
| **Chipped teeth** | ❑ Yes ❑ No | |
| **Missing teeth** | ❑ Yes ❑ No | |
| **Dental implants** | ❑ Yes ❑ No | |
| **Crowns** | ❑ Yes ❑ No | |
| **Bridges** | ❑ Yes ❑ No | |
| **Dentures** | ❑ Yes ❑ No | Top, bottom or both: |
| **Other/Notes:** | | |
| **ETOH / Illicit Drugs** | | |
| **Currently under a pain contract** | ❑ Yes ❑ No | |
| **Drink alcohol** | ❑ Yes ❑ No | How often: |
| **Smoke cigarettes** | ❑ Yes ❑ No | How many packs per day: |
| **Vape** | ❑ Yes ❑ No | How often: |
| **Marijuana** | ❑ Yes ❑ No | How often: |
| **Illicit drugs** | ❑ Yes ❑ No | What type of illicit drug: |

| | | |
|---|---|---|
| **Surgical History: Any surgeries you have had in the past (**If you can't remember the name of the surgery, list body part you had the surgery on**)** | | |
| _____<br>_____<br>_____ | | |
| **Any reactions to anesthesia?** | ❑ Yes ❑ No | **What type of reaction:** |
| **Any family members who have MH (malignant hyperthermia - a life-threatening condition that causes a dangerously high fever after getting anesthesia)** | ❑ Yes ❑ No **. If yes, What is your relationship to this family member:** | |

# MEDICATIONS: PLEASE LIST ALL OF YOUR MEDICATIONS

We need this list as soon as possible because some meds may need to be discontinued days or even a week prior to your procedure.
If a medication needs to be stopped ahead of time and we do not have your med list this could cause a delay in your procedure.
Include all prescriptions meds, over the counter meds, and any vitamins or supplements you currently take.

Include the following for **each** medication:

1. Name of medication
2. Dosage of the medication
3. How often you take the medication
4. The reason you take the medication

*For Example: "Lisinopril 10mg, taken 2X daily for high blood pressure"*

| ***Name of medication*** | ***Dosage of medication*** | ***How often you take*** | ***Reason for taking*** |
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**Please follow all instructions provided by your surgeon, as well as the additional guidelines below**

- After 11:59 PM the night before your procedure, please don't eat or drink anything, including water. The only exception: you may have a small sip of water with any medications we instruct you to take the morning of your procedure.
- Wear loose, comfortable clothing on the day of your procedure. Please avoid wearing tight-fitting clothing, including spandex and jeans.
  - For knee surgery: We recommend wearing shorts, loose-fitting sweatpants, a dress, or a skirt to allow room for dressings, braces, or bandages.
  - For hand, elbow, or shoulder surgery: We recommend wearing an oversized shirt or a button-front shirt to make dressing easier and more comfortable after your procedure.
- If you wear glasses, contact lenses, hearing aids, dentures, partial dentures, or retainers, please bring a protective case or storage container for each item. These items will need to be removed before your procedure and safely stored during surgery.
- Remove all jewelry and body piercings before arriving for your procedure. Wearing jewelry/body piercings during surgery may increase your risk of injury, including but not limited to: Electrical Burns, Infections, Skin tears, pressure ulcers, and pressure injuries, Loss of circulation and oxygenation, Fire, Damage to personal property not removed, etc.
- Please bring your insurance card, a valid photo ID, and a debit card, credit card, or cash to pay any required copay or patient balance. Please note that we are unable to accept personal checks.
- If you have a Medical Power of Attorney (MPOA), Advance Directive, Living Will, or other healthcare directive, please bring a copy with you on the day of your procedure.
- You must arrange for a responsible adult to:
  - Drive you home after your surgery. You will not be permitted to drive yourself or use public transportation or a rideshare service without a responsible adult accompanying you.
  - Be available at the time of discharge to receive and understand your post-operative instructions, sign any required discharge paperwork, and assist with your care at home.
- Please note: If you do not have a responsible adult available to accompany you home, your procedure may be delayed or rescheduled for your safety.
- We will give you a call one business day before your procedure to confirm your arrival time. Surgery schedules are ever changing and can change up to and including the day of your procedure.
  - If your surgeon's office has provided a different arrival time, please follow the arrival time given by Lake Ridge Ambulatory Surgery Center. The time provided by your surgeon's office is an estimate and may change based on the final surgical schedule.
- Occasionally, we may contact you on the day of your procedure and ask you to arrive earlier than your scheduled arrival time due to changes in the surgery schedule or a cancellation. Because surgery schedules can be unpredictable, we recommend planning your day with flexibility in case your surgeon needs to accommodate an earlier arrival.

Our Address is 12825 Minnieville Road, Suite 204, Woodbridge, VA 22192
Our Phone number is (703) 357 – 9568
Our Fax number is (703) 357 – 9575
Preop Email: assessmentrn@lakeridgesurgerycenter.com