James D. Atkinson, M.D., FACS Darren W. Soong, M.D., FACS Leduc, M.D., FACS Marvin Rivera PA

Patient information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (circle) M / F	Date of Birth	Marital Status (circle) Divorced - Married - Separated - Single - Widowed - Other	Preferred Language

Race (check all that apply) ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Patient Declined

Ethnicity (check all that apply) ❑ Hispanic or Latino ❑ Multiple ❑ Not Hispanic or Latino ❑ Patient Declined

Mailing Address	Apt/Lot	City/State	Zip code	Phone #s: Home ( ) Mobile ( ) Work ( )

Email Address	Primary Physician

Responsible Party/Parent/Guardian (circle one) Check if same as [ ] Patient

Last Name	First Name	Gender (circle) M / F	Date of Birth	What is Patient's relationship to responsible party?

Mailing Address	Apt/Lot	City/State	Zip code	Phone #s: Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City/State	Zip code

Insurance Information Check if [ ] Self pay

Primary insurance: Check if same as: [ ] Responsible Party		**Secondary insurance:** Check if same as: [ ] Responsible Party	
Insurance Name / Begin date		Insurance Name / Begin date	
Subscriber/Member Name / Date of Birth		Subscriber/Member Name / Date of Birth	
What is Patient's Relationship to Subscriber?	Gender (circle) M / F	What is Patient's Relationship to Subscriber?	Gender (circle) M / F
Insurance Mailing Address / City/State / Zip code		Insurance Mailing Address / City/State / Zip code	
Subscriber/Member # / Group #		Subscriber/Member # / Group #	

Patient Portal

To receive an invitation to register for the patient portal please ensure you have provided an e-mail address above.

Benefits of the patient portal include: 24/7 access online via a computer or smart phone app for yourself or a designated caregiver to view results and visit summaries, request prescription refills, update your demographics, and send secure messages directly to your provider's staff without having to pick up the phone.

To opt out of the patient portal please check one of the options below:

_____ I am not interested in signing up for the portal at this time _____ I do not have an e-mail address

_____ Patient/Legal Guardian Signature Date

_____ Patient/Legal Guardian Print

James D. Atkinson, MD, FACS
Marc Leduc, MD, FACS

Darren W. Soong, MD, FACS
Marvin Rivera PA-C

SURGICAL WEIGHT CONTROL CENTER
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices describes how Surgical Weight Control Center may use and disclose your protected health information to carry out treatment, payment of health care operation and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. **"Protected Health Information"** is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health and/or condition and related care services.

Surgical Weight Control Center is required to abide by the terms of this Notice and may change the terms of this notice at any time. The new notice would be effective for all protected health information maintained at this time. Upon your request , Surgical Weight Control Center will provide you with any revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent to you in the mail, or you may request one at the time of your next appointment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION
you will be asked to sign an authorization form for use and disclosure of your protected health information for specified reasons as outlined in the authorization form.

TREATMENT:

Surgical Weight Control Center will use and disclose your protected health information to provide, coordinate, or manage your health care and any related issues. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to this information (e.g., a home health agency that provides care to you). Surgical Weight Control Center will disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to do so (e.g., a physician for whom you have been referred to ensure that this physician has the necessary information to diagnose or treat you).In addition, Surgical Weight Control Center may disclose your protected health information from time to time to another health care provider (e.g., specialist or laboratory) who, at the request of your provider, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

PAYMENT:

Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves of pays for the health care services Surgical Weight Control Center has recommended for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities (e.g., obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admissions).

Healthcare Operations:
Surgical Weight Control Center May use or disclose your protected health information for the following reasons:

- In order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, and conduction or arranging for other business activities (e.g., we may disclose this information to medical students who see patients at our office).
- We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.
- To contact you to remind you of your appointment.
- To share with third party "business associates" who perform various activities (e.g., billing and transcription services) for the practice. Whenever an arrangement between Surgical Weight Control Center and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains the terms that will protect the privacy of your information

OTHER USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

Surgical Weight Control Center will employ other uses and disclosures of your protected health information only with you written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that your physician or Surgical Weight Control Center has taken action in reliance on the use or disclosure indicated in the authorization

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT

Surgical Weight Control Center may use and disclose your protected health information in the following instances: (note – you have the opportunity to agree or object to the use or disclosure of the protected health information; then your provider may, using professional judgement, determine whether the disclosure is in your best interest. In this case only the protected health information that is relevant to your health care will be disclosed.)

- Others involved in your health care: Unless you object, Surgical Weight Control Center may disclose to a member of your family, a relative, a close friend, or any other person that you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such disclosure, we may disclose such information as necessary if we determine that it is in your best interest, based on our professional judgement. We may disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care, general condition, or death. Finally we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
- Emergencies:
  Surgical Weight Control Center May use or disclose your protected health information in an emergency treatment situation. If this happens, your provider shall try to obtain your consent as soon as possible after the delivery of the treatment. If your provider or another provider in the practice is required by law to treat you and the provider has attempted to obtain your consent but is unable to do so, he or she may still use or disclose your protected health information to treat you.

- Communication Barriers:
  Surgical Weight Control Center may use and disclose your protected health information if you physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment, that you intend to consent to use or disclosure under any circumstances.

James D. Atkinson, MD, FACS
Marc Leduc, MD, FACS

Darren W. Soong, MD, FACS
Marvin Rivera PA-C

SURGICAL WEIGHT CONTROL CENTER

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE WITHOUT YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT;

Surgical Weight Control Center may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- Required by Law: The use or disclosure will be made in compliance with the law and will be limited to relevant requirements of the law. You will be notified, as required by law of any such disclosures
- Public Health Disclosure of information for public health activities and purposes may be released to a public health authority that is permitted by law to collect or received the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your information, if directed by the public health authority to a foreign government agency that is collaborating with the public health authority.
- Communicable Diseases: Information may be released, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- Health Oversight: Information may be released to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Abuse or Neglect: Information may be released to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose this information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- Food and Drug Administration: Disclosure of information may be release to a person or company required by the Food and Drug Administration to report adverse events, product defect or problems, biologic product deviations, to track products so as to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required
- Legal Proceedings: Information may be disclosed in the course or any judicial or administrative proceeding, in response to an order of a court of administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.
- Law Enforcement: Information may be disclosed, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and other required by law, (2) limited information request for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is unlikely that a crime occurred.
- Coroners, Funeral Directors, and Organ Donation: Information may be release to a coroner or medical examiner for identification purposes, determining cause of death or for the colorner or medical examiner to perform other duties authorized by law. We may also disclose information to a funeral director, as such information in reasonable anticipation of death. Information may be disclosed for cadaveric organ, eye, or tissue donation purposes.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- You have the right to request confidential communications from us by alternative means or at an alternative location. Surgical Weight Control Center will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the bases of this request. Please make this request in writing to our Practice Manager.
- You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases Surgical Weight Control Center may deny you request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement

and provide you with a copy of such rebuttal. Please contact our Practice Manager to determine if you have questions about amending your medical records

- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in the Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members, or friends involved in your care, or for notifications purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions, and limitations.
- You have the right to obtain a paper copy of this notice from us, upon request even if you have agreed to accept this notice electronically.

Waiver of rights:

Surgical Weight Control Center may not require individuals to waive their rights as a condition of the provision of treatment.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our Practice Manager of your complaint. We will not retaliate against you for the filing of a complaint.

Our practice manager can be reached at (702) 313-8446 for further information about the complaint process.

If you have any questions about this notice please contact our practice manager.

James D. Atkinson, MD, FACS
Marc Leduc, MD, FACS

Darren W. Soong, MD, FACS
Marvin Rivera PA-C

SURGICAL WEIGHT CONTROL CENTER

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH OPERATIONS.

UNDERSTANDING YOUR MEDICAL RELATED HEALTH RECORD INFORMATION

1. I understand that as part of my healthcare, Surgical Weight Control Center originates records and maintains health information about me describing my health history, current symptoms, diagnosis, treatments, test results, and any plans for future care or treatment. I understand that this health information may be used or disclosed by Surgical Weight Control Center for treatment, payment, and healthcare operations. This information, often referred to as my medical records, serves as:
    - **A means of communication among many healthcare professionals whom contribute to my care.**
    - **A basis for planning my care and treatment**
    - **A source of information for applying my diagnosis ad health information to my bill.**
    - **A means by which a third-party payor can verify that services billed were actually provided**
    - **A tool to assess the appropriateness and quality of care I received**
    - **A tool used to obtain accreditations and certifications.**

2. I acknowledge that I have been provided with Surgical Weight Control Center Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have a right to review the Notice of Privacy Practices prior to signing this consent. I understand that Surgical Weight Control Center reserves the right to change their Notice of Privacy Practices and will provide a revised copy upon request
3. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I further understand that Surgical Weight Control Center are not required to agree to the restrictions requested, but if they do, they are bound by such restrictions
4. I understand that I may revoke this consent in writing, except to the extent that Surgical Weight Control Center have already taken action in reliance thereon

By signing this form, I consent to let Surgical Weight Control Center use and disclose my health information for treatment, payment, and healthcare operations.

Signature:_____ Date:_____

Patient's Name(print): _____

Witness: _____

MBSAQIP
ACCREDITED CENTER

James D. Atkinson, MD, FACS
Marc Leduc, MD, FACS

Darren W. Soong, MD, FACS
Marvin Rivera PA-C

SURGICAL WEIGHT CONTROL CENTER

NOTICE of PRIVACY PRACTICE

A copy of Independence Physician Management's HIPAA Notice of Privacy Practices are posted in the main lobby and available for me to read in its entirety. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information ("PHI")

DISCLOSURE of PROTECTED HEALTH INFORMATION and EMERGENCY CONTACT

I authorize ***Independence Physician Management*** to communicate with the following individuals about my medical condition, diagnosis, treatment, appointments (past and future), and financial obligation. I understand medical information may be withheld from individuals, including family members, unless I list them by name below

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I authorize ***Independence Physician Management*** to leave voicemail or answering machine messages regarding test results or other healthcare related concerns at my home or cell phone number. Yes ☐ No ☐

Emergency Contact: _____ **Phone Number:** _____ **Relationship** _____

Email Address:_____

FINANCIAL POLICY and AUTHORIZATION for ASSIGNMENTS of BENEFITS

Independence Physician Management strives to make our financial policy, insurance filing, and billing process for our patients as simple as possible. It is your responsibility to make sure we have your correct insurance information and also your responsibility to know your co-pay, co-insurance amount and deductible. For Self-Pay patients, payment must be made at the time of service and a 50% discount is offered to those patients. Patients will be assessed a $30 fee for checks returned due to insufficient funds. Statements are mailed out each month. Please contact our Central Billing Office for questions or concerns regarding your balance. ***Independence Physician Management*** will submit claims to my primary and secondary insurance otherwise payable to me. Charges deemed as non-covered by insurance company are the responsibility of the patient except as required by law for State and Federal reimbursement programs. I authorize ***Independence Physician Management*** to release or receive any information necessary to expedite insurance claims.

GENERAL CONSENT for EXAMINATION AND TREATMENT

I hereby consent and authorize ***Independence Physician Management*** to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment, and healthcare operations of ***Independence Physician Management.*** Any photographs or other images taken will become part of my medical record. ***Independence Physician Management*** will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that ***Independence Physician Management*** will provide me with information and forms prior to such procedures. I grant ***Independence Physician Management*** consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize ***Independence Physician Management*** to search and access my records through a Health information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying ***Independence Physician Management.***

Patients Name (Print)_____ Signature:_____
Patients Representative_____ Signature:_____

MBSAQIP ACCREDITED CENTER

James D. Atkinson, MD, FACS
Marc Leduc, MD, FACS

Darren W. Soong, MD, FACS
Marvin Rivera PA-C

SURGICAL WEIGHT CONTROL CENTER

Prescription Pain Medication Agreement

Due to State laws governing the prescribing of controlled substances to treat pain, you are required to enter into an agreement with DSMG, your provider, regarding your responsible use of this medication prior to receiving a prescription. Please read through this document carefully.

I am being prescribed _____ as part of a total treatment plan. The foal of using this medication is _____Post-Operative pain control_____.

- I agree to strictly follow the treatment plan prescribed by my provider, and to keep all appointments required under the treatment plan such as; completing all Physical therapy-sessions and all diagnostic testing ordered by my provider, and scheduling and keeping appointments with Pain Management when directed.

- I agree to have my prescriptions filled at only one pharmacy. If I have to use another pharmacy, I agree to notify my Provider immediately.

- I will not request or accept a prescription for pain medication from any other provider except in cases of extreme emergency, unless I have been referred to that provider for the purpose of managing pain as part of this treatment plan. In the event that I receive a prescription for a controlled substance to treat pain from another provider for ANY reason, I agree to immediately report it to my LVMG provider.

- I understand I may be subject to urine/blood toxicology screening at my Providers discretion and may be subject to random pill counts. I understand that if I fail to consent to such screenings, I will be denied a prescription. I understand that using any alcohol or elicit substances may result in me being denied my pain medication by my PCP and/or being discharged from LVMG.

    - I understand that LVMG sends all toxicology testing to an independent lab and I *may* be responsible for a portion of that cost, and I agree to contact that lab directly with any billing questions.

- I agree to take my medication exactly as prescribed by my Provider. I will never take more than is prescribed, and I will notify my Provider before discontinuing any medication
.
- I understand that I will not under any circumstances be able to get early refills of my medication, and prescriptions will not be available without an appointment during office hours, evenings, weekends, or on holidays.

- I agree not to share, give away, or sell my medication to any other person.

James D. Atkinson, MD, FACS
Marc Leduc, MD, FACS

Darren W. Soong, MD, FACS
Marvin Rivera PA-C

- I will keep my medication safe and secured at all times. If stolen a police report must be filed and a copy brought to the office.
- I understand that if my medication is lost or stolen I may not receive a refill and may have to wait until my next scheduled appointment to receive additional medication.
- I understand that with the use of any controlled substance there is a risk of drug addiction and/or dependence and that if I abruptly stop or significantly reduce my dose, I may experience symptoms of withdrawal.
- I understand that under this agreement, I am required to immediately inform my provider of all of the following.
    - If I use any alcohol, cannabinoid, or other illicit drugs.
    - If I use any other controlled substances whether prescribed or obtained through other means
    - If I have ever been treated for, or if I seek treatment for side effects of complications stemming from the use of this or similar medications.
    - Every state in which I have previously filled a prescription for controlled pain medications.
- I understand that non-adherence to any of the above requirements may result in my no longer being prescribed pain medication, and that in certain circumstances; I may be discharged from the practice.

As a patient of DSMG I acknowledge I have read, understand, and agree to the policy above and will comply with all provisions. I understand that if I do not comply with my treatment plan or these actions as agreed, I may be denied medication refills and/or may be discharged from the practice

I authorize my provide and my pharmacy to cooperate fully with any city, state or, federal law enforcement agency, including the State Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy or any regulatory agency if requested.

I understand that a copy of this document will be provided to me upon request.

Patient Name	Patient Date of Birth
Patient Signature	Date
Provider Signature	Date

James D. Atkinson, MD, FACS
Marc Leduc, MD, FACS

Darren W. Soong, MD, FACS
Marvin Rivera PA-C

SURGICAL WEIGHT CONTROL CENTER

COMM™

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never** 0	**Seldom** 1	**Sometimes** 2	**Often** 3	**Very Often** 4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

ACCREDITED CENTER

James D. Atkinson, MD, FACS
Marc Leduc, MD, FACS

Darren W. Soong, MD, FACS
Marvin Rivera PA-C

Please answer the questions using the following scale:	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O

PRE-ANESTHESIA RECORD

Chief Complaint:_____ Height: Weight:

In own words, what procedure are you having done? _____

Any pressure ulcer present during admission:

❑ No ❑ Yes Where:_____

Highest level of education completed:_____

Able to read/write: ❑ No ❑ Yes

Preferred delivery of education: ❑ Reading ❑ Written ❑ Demonstration ❑ Sign Language

❑ Verbal ❑ Interpreter ❑ Language communicated ❑ Other:_____

OBGYN History

Menstrual status/LMP: _____

Postmenopausal/Post GYN Procedure: _____

Currently breastfeeding/pumping: _____

Pregnancy status: _____

TB Risk Factors

Any history of Tuberculosis or exposure:_____

Any of the following symptoms (check all that apply):

❑ Bloody sputum	❑ Sputum expectoration greater than 2 weeks	❑ Chest Pain
❑ Night sweats	❑ Persistent cough greater than 3 weeks	❑ Fever
❑ Chills	❑ Weight loss greater than 10 lbs	❑ Loss of appetite
❑ Weakness and fatigue	❑ Shortness of breath	❑ NO symptoms of TB

Recent exposure to communicable disease: ❑ No ❑ Yes

When and what disease exposure:_____

In the last 21 days, have you traveled out of the country, been on a cruise or experienced symptoms such as fever or chills, chough, shortness of breath, fatigue, muscle or body aches, headache, NEW loss of teste or smell, sore throat, congestion or runny nose, nausea, vomiting or diarrhea?

❑ No ❑ Yes Where:_____ When did you return:_____

In the last 21 days have you been tested for COVID-19?

❑ No ❑ Yes Date tested:_____

Have you received the COVID-19 vaccine? (Please make sure you bring a copy of your vaccination card by day of surgery)

❑ No ❑ Fully +1 or more booster ❑ Fully (>2 weeks since last dose) ❑ Partial

Have you had 3 or more liquid stools in the past 24 hours with no etiology? EX: bowel prep, tube feeding or enema/laxative:

❑ No ❑ Yes

MRSA SCREENING

History of MRSA in the last 6 months: _____

Discharged from an acute facility within the past 30 days: _____

Admitted from anywhere other than home: _____

Receiving HD of have venous access such as PICC line, Vascath: _____

IV Drug use: _____

PRE-ANESTHESIA RECORD

Current Living Situation

Whom do you live with: _____

Do you use any of the following at home:

- ❑ Apnea monitoring
- ❑ Blood glucose monitoring
- ❑ IV therapy
- ❑ Nebulizer treatments
- ❑ Oxygen therapy
- ❑ Radiation therapy
- ❑ TPN
- ❑ Bipap
- ❑ Cardiorespiratory monitoring CPAP
- ❑ Mechanical ventilation
- ❑ Ostomy care
- ❑ Peritoneal dialysis
- ❑ Last radiation: _____
- ❑ Tube feeding
- ❑ Wound care
- ❑ Cane
- ❑ Crutches
- ❑ Walker
- ❑ Other: _____

Resources

- ❑ Mobile meals
- ❑ Department of human services
- ❑ SSD/SSI
- ❑ WIC
- ❑ Office of aging
- ❑ Transportation
- ❑ Lifeline
- ❑ Military benefits

Pain

Pain 0 - 10: _____

Please describe. Any radiation or associated symptoms:

_____

Last bowel movement: _____

Any history of sleep apnea: ❑ No ❑ Yes

Usual hours of sleep per night: _____

Functional

Sensory deficits:

- ❑ Blindness: L / R / both eye
- ❑ Hearing deficit: L / R / both ear
- ❑ Nonverbal: Speech deficit
- ❑ Uncorrected visual impairment: L / R / both eye
- ❑ Correct visual impairment: L / R / both eye

Assisted devices such as:

- ❑ Hearing aids
- ❑ Dentures — Upper / Lower / Both
- ❑ Glasses — Magnifier
- ❑ TTY/TDD — Large print materials
- ❑ Other: _____

At home mobility:

❑ Independent ❑ Partial assistance ❑ Total assistance ❑ Immobile

Date of last EKG: _____

Date pacemaker/AICD check: _____

(PLEASE BRING COPY OF PACEMAKER/AICD CARD FOR SURGERY)

PRE-ANESTHESIA RECORD

Health History

	Yes	No
Acid Reflux	❑	❑
AIDS	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Back Problems	❑	❑
Blackout	❑	❑
Bleeding Tendencies	❑	❑
Blood Transfusion	❑	❑
Cancer Type:_____	❑	❑
Cataract	❑	❑
Chest Pain / Angina	❑	❑
Chronic Cough	❑	❑
COPD	❑	❑
Diabetes	❑	❑
Emphysema	❑	❑
Fibromyalgia	❑	❑
Glaucoma	❑	❑
Gout	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Hepatitis Type:_____	❑	❑

	Yes	No
Hernia	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Kidney Disease	❑	❑
Liver Disease	❑	❑
Muscle Disease	❑	❑
Neuropathy	❑	❑
Osteoporosis	❑	❑
Palpitations	❑	❑
Prostate Problems	❑	❑
Rheumatic Fever	❑	❑
Seizures Last episode:_____	❑	❑
Shortness of Breath	❑	❑
Sickle Cell Anemia	❑	❑
Sleep Apnea	❑	❑
Snoring	❑	❑
Stiff Jaw or Neck	❑	❑
Stroke	❑	❑
Thyroid Problem	❑	❑
TIA	❑	❑
Ulcers Gastric or Pressure Ulcer	❑	❑
Others not mentioned:	❑	❑

Bowel Issues: ❑ Incontinence ❑ Constipation ❑ Diarrhea ❑ Bloody Stools ❑ Ostomy

Bladder Issues: ❑ Incontinence ❑ Retention ❑ Obstruction ❑ Bloody urine
❑ Dialysis: access and frequency:_____

	Yes	No
Any history of suicidal ideation?	❑	❑
Have you been threatened or physically hurt by someone within the past year?	❑	❑
Any history of domestic abuse?	❑	❑
Have you been a participant in a clinical trail: Diabetic, Asthma, CHF, Oncology, Stroke, Pneumonia, Other:_____	❑	❑

Spiritual

Faith/Denomination:_____

Any religious practices you'd like us to honor?

Family History

	Father	Mother	Brother	Sister
Cardiac Complication	❑	❑	❑	❑
Cancer	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑
Liver Disease	❑	❑	❑	❑
Diabetes:	❑	❑	❑	❑

PRE-ANESTHESIA RECORD

Previous Surgeries

Please list previous surgeries and approx. dates: _____

_____

_____

Any implantations ot prothesis? _____

Prior history of anesthesia? _____

Any reactions noted; such as difficulty waking up, post op nausea and vomiting, malignant hyperthermia?

_____

Social History

Alcohol: Last drink: _____ How frequently: _____

Alcohol of choice: _____

Tobacco: Last used: _____ Years used: _____

Method of consumption: _____

Recreational drugs: Last used: _____ How frequent: _____

Do you snore loudly: ❑ No ❑ Yes

Do you often feel tired, fatigued, or sleepy during the day: ❑ No ❑ Yes

Has anyone observed you stop breathing or choking/gasping during your sleep: ❑ No ❑ Yes

Do you have high blood pressure: ❑ No ❑ Yes

Medications / Vitamins / Supplements taken in the last 30 days

Medication Name	Dose	Frequency

Continue on next page if there are more medications

Allergies	Reaction Type

Advance Directive or Living Will? ❑ No ❑ Yes

Emergency contact (name, number, relation): _____

Ride Contact (name, number): _____

_____ _____ _____

Patient Signature Date Time

_____ _____ _____

RN Signature Date Time

BAR CODE

OP1023

OP1023

SPRING VALLEY HOSPITAL MEDICAL CENTER

PRE-ANESTHESIA RECORD

(PMM# 55890) (R 9/22) (FOD)

PATIENT IDENTIFICATION

PRE-ANESTHESIA RECORD

Medications / Vitamins / Supplements taken in the last 30 days

Medication Name	Dose	Frequency

BAR CODE

OP1023

OP1023

SPRING VALLEY HOSPITAL MEDICAL CENTER

PRE-ANESTHESIA RECORD

(PMM# 55890) (R 9/22) (FOD)

PATIENT IDENTIFICATION