Ambulatory Surgery Center of Western New York
3112 Sheridan Dr.
Amherst, NY 14226

SELF REPORTING HEALTH HISTORY

FORM TO BE COMPLETED BY PATIENT

PLEASE PRINT Patient Name_____
Patient Address_____
Patient Phone#_____Emergency Contact/ Phone #_____
Patient DOB_____

PRIMARY CARE PHYSICIAN NAME_____
ADDRESS OF PRIMARY PHYSICIAN_____
PHONE NUMBER OF PRIMARY PHYSICIAN_____

Height_____ Weight_____

Allergies: List all drug allergies

Drug	**Reaction**
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

Other types of allergies:

**** Latex allergy** ☐ **Yes** ☐ **No**

Food or Material	**Reaction**
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

Are you hearing impaired? ☐ No ☐Yes (Explain)_____
Do you have bleeding problems? ☐ No ☐ Yes (Explain)_____
Are you currently taking blood thinners ☐ No ☐ Yes (Explain)_____
Do you have problems breathing through your nose? ☐No ☐ Yes (Explain)_____
Do you have limited range of motion within any joints (jaw)? ☐No ☐ Yes (Explain)_____
Smoking: ☐No ☐Yes Cigarettes Per Day____No. of yrs.____
If you quit-when_____
Do you drink alcohol? ☐No ☐Yes Amounts_____ No. of Years_____
Recreational drugs ☐No ☐ Yes
History of Malignant Hyperthermia (Family Members): ☐No ☐Yes
(HIGH FEVERS FOLLOWING ANESTHESIA)
Describe_____

Check any condition that applies to you and explain briefly:

Anemia	**No**	**Yes**_____	**Mental Illness**	**No**	**Yes**_____
High blood Pressure	**No**	**Yes**_____	**Stroke/Weakness Arm/Leg**	**No**	**Yes**_____
Chest Pain/Angina	**No**	**Yes**_____	**Heart Attack or Failure**	**No**	**Yes**_____
Diabetes	**No**	**Yes**_____	**Hepatitis/Jaundice/Cirrhosis**	**No**	**Yes**_____
Rheumatic Fever	**No**	**Yes**_____	**Kidney/Urinary/Problems**	**No**	**Yes**_____
Mitral Valve Prolapse	**No**	**Yes**_____	**Stomach Prob/Hiatal Hernia**	**No**	**Yes**_____
Irregular Heart Beat	**No**	**Yes**_____	**Bronchitis**	**No**	**Yes**_____
Other Heart Disease	**No**	**Yes**_____	**Asthma**	**No**	**Yes**_____
Thyroid Disease	**No**	**Yes**_____	**Emphysema**	**No**	**Yes** _____
Motion Sickness	**No**	**Yes**_____	**Seizures/Epilepsy**	**No**	**Yes**_____
Tuberculosis	**No**	**Yes**_____	**Paralysis**	**No**	**Yes**_____
Shortness of Breath:	**No**	**Yes**_____	**Back Problems**	**No**	**Yes**_____
During Rest	**No**	**Yes**_____	**Black Out Spells**	**No**	**Yes**_____
During Mild Exercise	**No**	**Yes**_____	**Blood Thinners**	**No**	**Yes**_____
Cough	**No**	**Yes**_____	**<u>FEMALES ONLY:</u>**		
Do you currently have a cold?	**No**	**Yes**_____	**Possibility of Pregnancy**	**No**	**Yes**_____
			Date of Last Period_____		

Other Medical Conditions_____

Body Piercings **No** **Yes**_____

If yes, Where?_____

CURRENT MEDICATIONS/OVER THE COUNTER VITAMINS & DOSAGES

MEDICATIONS	DOSAGES	FREQUENCY	LAST TIME TAKEN

HAVE YOU HAD ANY OPERATIONS IN THE PAST? NO YES PLEASE LIST

OPERATION	DATE	OPERATION	DATE

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DO YOU CURRENTLY HAVE ANY OF THE ADVANCE DIRECTIVES LISTED BELOW?

HEALTH CARE PROXY	☐ YES	☐ NO
LIVING WILL	☐ YES	☐ NO
"DO NOT RESUSCITATE" ORDER	☐ YES	☐ NO

I have provided a copy of my Advance Directives for my medical record.
I have received information about Advance Directives.
I understand that Advance Directives are not acted upon during elective surgery.
I have received information on my rights and responsibilities as a patient.
I have been informed of the Physician ownership of the ASC of WNY
I have been provided the information listed above, prior to my surgery in a language that I understand. _____ (patient init.)

DO NOT WRITE BELOW THIS LINE

SCHEDULED PROCEDURE:				
BLOOD PRESSURE	TEMP	PULSE	RESP	SaO2 on room air
1. CONSENT FORM SIGNED/DATED/WITNESSED ☐ 2. NPO ☐ 3. PATIENT TEACHING COMPLETED ☐ 4. I.D. BAND ☐ DOB ☐ PROCEDURE REVIEWED WITH PATIENT ☐				NURSES NOTES: _____ _____ _____ _____

	YES	NO	DESCRIPTION	
CONTACT LENSES				
DENTURES				
HEARING AID				

NURSING DIAGNOSIS: Potential for anxiety, patient knowledge deficit. GOAL: Decrease patient anxiety through education

Skin Condition:	LOC:
☐ intact ☐pale ☐warm ☐ flushed ☐diaphoretic ☐cool	☐alert ☐sedated ☐agitated ☐confused ☐oriented ☐ anxious ☐unresponsive

TRANSPORTED TO OR VIA: AMBULATORY WITH ASSIST ☐WHEELCHAIR ☐STRETCHER ☐

NURSES SIGNATURE:_____