

South Bay Hospital *Caring for You*

Pre-Operative Patient Information Form

Please complete this form to the best of your ability and fax it to 813-634-0283 at least 48 hours prior to your Pre-Operative Appointment. If you do not have access to a fax machine, please bring the completed form with you to your pre-operative appointment.

Patient Name _____

Age _____

Gender _____

Height _____

Weight _____

Advance Directives

Do you have a Living Will? Yes / No
(If yes, please bring a copy with you)

Do you have a Durable Medical Power of Attorney? Yes / No
(If yes, please bring a copy with you)

Do you have a Health Care Surrogate? Yes / No
(If yes, please bring a copy with you)

Would you like to initiate / update Advance Directives? Yes / No

Would you like information regarding Advance Directives? Yes / No

Are you an Organ Donor? Yes / No

Medications

Do you take Over the Counter / Herbal / Holistic Medications? Yes / No

Are you part of an Investigational Drug Study? Yes / No

What pharmacy do you go to? _____ Phone # _____

Please list your current medications, including Over the Counter / Herbal / Holistic Medications:

Medication	Dose / Frequency
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

If you take more than 10 medications, please attach additional medication list to the back of this form.

Previous Surgeries/Procedures

Please list any previous surgeries you have had:

1. _____
2. _____
3. _____
4. _____
5. _____

If you have had more than 5 surgeries, please attach additional surgery list to the back of this form.

Have you had problems with prior anesthesia? Yes / No
If yes, what type of problem: _____

Do you have a family history of anesthesia problems? Yes / No
If yes, what type of problem: _____

Communicable Disease History

Have you ever been infected with a Drug Resistant Organism (exp. MRSA)? Yes / No

If yes, what type: _____

Do you or have you had Hepatitis? Yes / No

Do you or have you had a Communicable Disease? Yes / No

If yes, what disease: _____

Have you had a TB Screening? Yes / No

If yes, what was the date of your screening: _____

What was the result of your screening: _____

Vaccines

Have you had the Influenza Vaccine since September 1st? Yes / No

Have you had the Pneumonia Vaccine within the past 5 years? Yes / No

Social History

Have you ever used any of the following?

Tobacco: Yes / No

How many packs do you smoke per day? _____

How many years have you been smoking? _____

Alcohol: Yes / No

How often do you drink alcohol? _____

What type of alcohol do you drink and how much? _____

Drugs: Yes / No

What type of drugs do you use? _____

When is the last time you used drugs? _____

