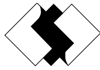

Lattimore Community Surgicenter
125 Lattimore Road
Rochester, New York 14620
Phone (585) 473-9000 • Fax (585) 473-9018

PLEASE MAIL OR FAX THIS FORM BACK TO THE CENTER WITHIN FIVE BUSINESS DAYS OF RECEIPT TO INSURE APPROPRIATE TIME FOR CLINICAL REVIEW OF YOUR HEALTH HISTORY

PLEASE COMPLETE ENTIRE FORM

Name: ____________________________ D.O.B. ________________Age: ______ Sex: M F

Please list all available phone numbers

Address: ____ Phone: ___________________ (Home)

____ Phone: ___________________ (Work)

Phone: ___________________ (Cellular)

Surgeon: ___________________________ Date of Surgery: __________________

Procedure: ___________________________ **Height:** ___________**Weight:** ___________

Primary Care Physician: ___________________________ PCP Phone #: _____________________________

Date of last physical: _______________________ Date of last EKG: ______________________________

May we have your permission to leave a voicemail/message at your: Home? Work? Cell? (Circle)

May we leave a message with other household members? ☐ Yes ☐ No

Allergies (attach additional page if necessary)

Allergies: (Drug allergies & other allergies) ☐ Yes ☐ No (If yes, please list below, with reaction)

____

____

____

Do you have a latex allergy? ☐ Yes ☐ No If Yes, reaction: _____________________________________

Medications ☐ Yes ☐ No **(attach additional page if necessary)**

If yes, please list all medications you are currently taking (Including Prescriptions, Over-the-counter, Herbals, Patches, Inhalers, Eye Drops, Supplements, Vitamins, and Aspirin)

Drug Name	**Dose**	**Frequency (how often)**

Have you had surgery (including oral surgery) before? ☐ Yes ☐ No

If you have had prior surgeries, please list below with approximate month/year and type of anesthesia

____

____

____

Last hospitalization: Location?________________________________When? _______________________

Why? ____

Anesthesia

Do you have a reaction to anesthesia? ☐ Yes ☐ No

If yes, describe reaction: ____

Does someone in your family have a reaction to anesthesia? ☐ Yes ☐ No

If yes, describe reaction: ____

PLEASE TURN PAGE

NO	YES	
☐	☐	Pregnant? Method of birth control: ____________________
☐	☐	Alcohol ☐ Social ☐ Daily What type? __________ How much? __________
☐	☐	Do you or have you ever used tobacco products? What type? __________
		How much? ____________________ Have you quit? ☐ Yes ☐ No
☐	☐	Recreational/Street Drug use? If Yes, what type? ____________________
		How much? ____________________ Have you quit? ☐ Yes ☐ No
☐	☐	Sleep apnea ☐ Sleep studies ☐ Yes ☐ No When? ______ Where? ________
☐	☐	CPAP machine How long? __________
☐	☐	In the past month have you had ☐ Bronchitis ☐ Pneumonia ☐ Cold/Flu
		If yes, medication____________________
☐	☐	☐ COPD ☐ Emphysema ☐ Chronic Bronchitis
☐	☐	Asthma How long? ____________________ Steroids ☐ Yes ☐ No
☐	☐	Home oxygen If yes, how long ______________ Liters per minute __________
☐	☐	High blood pressure How long? __________
☐	☐	☐ Chest pain ☐ Palpitations ☐ CHF ☐ Heart attack When? __________
☐	☐	☐ MVP ☐ Other Heart Murmur ____________________
☐	☐	Cardiologist If yes, name & phone number ____________________
☐	☐	Cardiac testing If yes, type & date ____________________
☐	☐	Pacemaker If yes, when ______________ Type ______________
☐	☐	**Defibrillator/AICD**
☐	☐	Can you walk either one block or take a flight of stairs without stopping?
		If no, explain ____________________
☐	☐	☐ Hiatal hernia ☐ Acid Reflux ☐ Crohn’s ☐ Ulcer ☐ Hepatitis
☐	☐	Bleeding problem Type? ____________________
☐	☐	Diabetes If yes, How long? __________ Average blood sugar __________
☐	☐	☐ Insulin dependent ☐ Non-insulin dependent ☐ Diet controlled
☐	☐	Kidney disease Type? ____________________ Dialysis ☐ Yes ☐ No
☐	☐	Thyroid disease?
☐	☐	Lower back pain
☐	☐	Physical limitations Explain ____________________
☐	☐	Arthritis ☐ Osteo ☐ Rheumatoid ☐ Other ____________________
☐	☐	Pain score 1-10? __________
☐	☐	Neck surgery If yes, when ______________ Where ______________
☐	☐	Neck Immobility Explain ____________________
☐	☐	Epilepsy/Seizures When ______________ Type ______________
☐	☐	Stroke If yes, when ______________ Limitations______________
☐	☐	Mini-stroke
☐	☐	Alzheimer’s/dementia
☐	☐	Developmental delays
☐	☐	Do you need an interpreter Language ____________________

Patient’s Signature ______________________________Date __________