Baylor Scott & White
SURGICAL HOSPITAL AT SHERMAN
Joint ownership with physicians

Patient Name: ____

In order to provide the best quality care for your procedure, you or your family need to answer the following questions.
If you have any questions about this form or the pre-assessment process, give our pre-op nurse a call at 903.870.0986.

	Have you had:	Yes	No
1	Recenty, a cold or flu	☐	☐
2	Heart condition	☐	☐
3	High blood pressure	☐	☐
4	Low blood pressure or fainting	☐	☐
5	Asthma, Bronchitis, Emphysema or other lung disease	☐	☐
6	Epilepsy or seizures	☐	☐
7	Jaundice, hepatitis, mononucleosis	☐	☐
8	Cancer	☐	☐
9	Back or neck problems	☐	☐
10	Abnormal chest x-ray	☐	☐
11	Abnormal electrocardiogram	☐	☐
12	Glaucoma	☐	☐
13	Any mental or emotional problems	☐	☐
14	Anticoagulant therapy (blood thinners)	☐	☐
15	Any blood disorders	☐	☐
16	Kidney disease	☐	☐
17	Fracture of facial bones	☐	☐
18	Fracture of neck or back	☐	☐
19	Muscle weakness, numbness, paralysis	☐	☐
20	Blood transfusion	☐	☐
21	Stroke	☐	☐
22	Any prosthetic device	☐	☐
23	Diabetes: ____ diet control ____ oral med ____ insulin	☐	☐
24	Other medical illnesses: __________________________	☐	☐
25	A positive HIV/AIDS blood test	☐	☐
26	Motion sickness	☐	☐
27	History of Sickle Cell Trait or Disease	☐	☐
28	Reactions to Band-aids, balloons, tape, rubber gloves or elastic products	☐	☐

	Do You:	Yes	No
1	Have false or loose teeth	☐	☐
2	Have dental caps or bridges	☐	☐
3	Wear contact lenses	☐	☐
4	Smoke: How many packages/day _________	☐	☐
5	Use alcoholic beverages	☐	☐
6	Have a history of substance abuse	☐	☐
7	Have any problems to discuss with the Anesthesiologist	☐	☐
8	Have a pacemaker	☐	☐
9	Have own blood donated	☐	☐
10	Object to a transfusion	☐	☐
11	Have any cultural/ethnic practices affecting care	☐	☐
12	Women Only: To the best of your knowledge, are you pregnant? Date of last menstrual cycle _____________	☐	☐
13	Religious preference: ____________________________	☐	☐
14	Support System (usually next of kin) ______________________________ Phone #	☐	☐

List previous surgeries (type and date):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

Previous Anesthetic History:

1. Date of last anesthetic: ______________________________
2. Any abnormal reactions? ☐ Yes ☐ No
3. Relatives with abnormal reactions to anes.? ☐ Yes ☐ No
4. Comments: ______________________________

____

List all medications you are presently taking:

Dosage Frequency Last Dose

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

Asprin - how many a day ______________________________

List Allergies (drug, food, etc.)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

I certify the above information is correct

____

Patient Signature

Phone (____) _____ - ________ Work (____) _____ - _________

Hospital Use Only

Pre-Op Call Completed: ☐ Yes ☐ No

Vital Signs

wt __________________ ht _______________ age

Reviewed by ______________________________

Date: ____________ Time: ______________ RN

***** Please print this form and either: 1) fax to 903.813.3780 or 2) bring with you to pre-op appointment at the hospital *****