EMMAUS SURGICAL CENTER

Patient Sticker
(to be applied at center)

Medical History

Allergies: _____ **Latex Allergy:** ☐ Yes ☐ No

Height: _____ Weight_____
Primary Care Doctor: _____

Please CHECK all that apply

Cardiac/Circulatory:
☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Attack ☐ Heart Disease ☐ Murmur
☐ Congestive Heart Failure ☐ Valve Replacement ☐ Pacemaker/Defibrillator ☐ Stents
☐ Blood Clots ☐ Anemia/Blood Disorder ☐ Mitral Valve Prolapse ☐ Irregular Heartbeat/A-Fib
☐ Other: _____

Endocrine:
☐ Diabetes: Oral ____ Insulin ____ ☐ Thyroid Disease

Gastrointestinal/Nutritional:
☐ Change in bowel habits ☐ Hiatal Hernia ☐ Reflux/GERD ☐ GI Bleed ☐ GI Ulcer
☐ Abdominal Pain ☐ Unintentional Weight Loss/Gain ☐ Diverticulosis/itis ☐ Hepatitis/Liver Disease

Genitourinary:
☐ Enlarged Prostate ☐ Renal Failure/Disease ☐ Kidney Stones ☐ Bladder Issues ☐ Stents
☐ Other: _____

Musculoskeletal:
☐ Arthritis ☐ Osteoporosis ☐ Osteopenia ☐ Chronic Pain ☐ Spinal/Disc Disease
☐ Other: _____

Neurological Health:
☐ Seizures/Epilepsy ☐ Paralysis ☐ Psychiatric Illness ☐ Neuropathy ☐ Headaches/Migraines
☐ Fainting/Dizzy Spells ☐ Anxiety/Depression ☐ Stroke/Mini Stroke ☐ Raynaud's ☐ Fibromyalgia
☐ Other: _____

Respiratory:
☐ Asthma ☐ Pneumonia ☐ Sleep Apnea ☐ Chronic Cough ☐ Pulmonary Embolism ☐ COPD
☐ Emphysema ☐ Tuberculosis ☐ Shortness of Breath: Cause:_____

☐ Cancer Type:_____

Other:_____

Treated for Lyme Disease: ☐ No ☐ Yes

Treated for Drug Resistant Organism (MRSA, C-Diff): ☐ No ☐ Yes

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Previous Surgeries/Procedures:

_____

_____

_____

Prior Colonoscopy: □ YES □ NO Last one: _____ How many total: _____

Medical Implants/Replacements (Type and Location):_____

_____

Life threatening reaction to anesthesia for you or any relatives: _____

_____

Social History:

Alcohol Use: ☐ None ☐ Occasional ☐ Social ☐ Moderate ☐ Heavy

Tobacco Use: ☐ No: ☐ Yes Packs/Day _____ Years____ ☐ Years Since quitting _____

Recreational Drug Use: ☐ No ☐ Yes Type: _____

Recent illness or exposure to communicable disease (Flu, Measles, Mumps, etc.): ☐ No ☐ Yes

Travel Outside the country in the last 6 months: ☐ No ☐ Yes (any illness related to travel)

_____

History of any abuse: _____

Religious or cultural needs: _____

Concerns regarding the procedure: _____

Person that will taking you home: _____ Their relationship to you: _____

Will be the waiting area: ☐ No ☐ Yes Phone number that they can be reached at: _____

Medical information can be shared with Family Member/person being discharged to: ☐ No ☐ Yes

Patient Signature: _____ Date: _____