

LAKELAND SURGICAL & DIAGNOSTIC CENTER, LLP

PLEASE COMPLETE AND BRING WITH YOU TO THE SURGERY CENTER

NAME: _____ Height: _____ Weight: _____

ALLERGIES (INCLUDE Drugs, Food, Rubber/Latex, Materials)

MEDICATIONS (List all prescriptions and over the counter medications – INCLUDING Herbal Products, Vitamins, and Dietary Supplements). Please document the dosage and how many times a day you take it.

MEDICATIONS stopped prior to procedure: _____

LIST PAST AND CURRENT DIAGNOSES OR PROBLEMS INCLUDING PAST PROCEDURES AND SURGERIES:

PLEASE CHECK IF YOU HAD A HISTORY OF -OR- CURRENTLY HAVE ANY OF THESE CONDITIONS:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Stones | | <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> Heart/Chest Pains | <input type="checkbox"/> Problems Urinating | | Bleeds easily/Clotting problems |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Liver Problems | | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Heart Bypass Surgery | <input type="checkbox"/> Hepatitis | | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Alcohol Use – How much | | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Pacemaker/Internal Defibrillator | each day? _____ | | <input type="checkbox"/> Artificial Joints/Metal Implant |
| <input type="checkbox"/> HeartCath/Stent/Angioplasty | <input type="checkbox"/> Illicit Drug Use – How much | | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Rheumatic Fever | each day? _____ | | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Irregular Heart Rhythm | <input type="checkbox"/> Glaucoma | | <input type="checkbox"/> Artificial Eyes, Limbs or Implants |
| <input type="checkbox"/> Valve Disease or Heart Murmur | <input type="checkbox"/> Problems Moving Neck/Jaw | | <input type="checkbox"/> Eyeglasses/Contact lens |
| <input type="checkbox"/> Smoker – How many packs a day? | <input type="checkbox"/> Stroke/TIA | | <input type="checkbox"/> Dentures/Partials |
| _____ Quit date? _____ | <input type="checkbox"/> Seizures | | <input type="checkbox"/> Loose Teeth |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Myasthenia Gravis | | <input type="checkbox"/> Hearing Aid(s) R L Both |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Mental Health Problems | | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Antibiotic resistant infection |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heartburn/Acid Reflux | | i.e. MRSA |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Difficulty Swallowing | | |
| <input type="checkbox"/> Difficulty Breathing | | | |
| <input type="checkbox"/> Cancer | | | |

PATIENT DIAGNOSTIC SUMMARY

