Patient Interview Form

Patient Information

SURGERY CENTER OF NORTHERN COLORADO, LLC
3151 Precision Drive, Fort Collins, CO 80528
(970) 419-2681

Name _____ Date of Birth _____

Weight _____ Height _____ *FOR OFFICE USE ONLY: BMI* _____

Preferred Language ☐English ☐Spanish Other: _____

Are you allergic to any medications? ☐No ☐Yes

If yes, please list and describe your reaction: _____

_____

I have an Allergy to Latex or Rubber ☐No ☐Yes

I have had LASIK or PRK ☐No ☐Yes

I wear contact lenses ☐No ☐Soft ☐Hard

I have taken a medication called Flomax or Tamsulosin ☐No ☐Yes

I currently take a GLP-1 medication ☐No ☐Yes

Name: _____

I have had difficulties with anesthesia in the past ☐No ☐Yes

If yes, please explain ☐Nausea /Vomiting ☐Other _____

I have been told that you have a difficult airway ☐No ☐Yes

A close relative or I have a history of Malignant Hyperthermia ☐No ☐Yes

I drink alcohol ☐No ☐Yes If yes, _____ drinks(s) per ☐Day ☐Week

I use marijuana ☐No ☐Yes

I recreational drugs ☐No ☐Yes If yes, list: _____

Someone else holds power of attorney on my behalf ☐No ☐Yes

I have advanced directives ☐No ☐Yes

If you have an advance directive please provide documentation

DO YOU OR HAVE YOU HAD IN THE PAST ANY OF THE FOLLOWING MEDICAL CONDITIONS?

(CHECK ALL THAT APPLY)

HEART CONDITIONS: *(CHECK ALL THAT APPLY)*

- ☐ HIGH BLOOD PRESSURE
  - ☐ **I TAKE BP MEDICATIONS**

  Typical BP: _____
- ☐ PULMONARY HYPERTENSION
- ☐ HEART DISEASE/CARDIOMYOPATHY
- ☐ CONGESTIVE HEART FAILURE

  When: _____
- ☐ HEART SURGERY IN LAST 120 DAYS?

  Describe: _____
- ☐ HEART ATTACK

  When: _____
- ☐ PACEMAKER / AICD

  Date Implanted: _____
- ☐ CORONARY ARTERY DISEASE (CAD)
- ☐ TAKE BLOOD THINNERS?
- ☐ ATRIAL FIBRILLATION (A-FIB)

☐ IF YOU HAVE CHECKED ANY BOXES IN THIS SECTION, CHECK THIS BOX IF YOU ARE **NOT** ABLE TO WALK UP 2 FLIGHTS OF STAIRS OR AROUND THE GROCERY STORE

LUNG CONDITIONS: *(CHECK ALL THAT APPLY)*

- ☐ SLEEP APNEA
  - ☐ **I use a CPAP**
  - ☐ **I use a BIPAP**
- ☐ SMOKER / TOBACCO USE

  How many daily? _____

  How often? _____
- ☐ RECENT COUGH OR COLD?

  When? _____
- ☐ TRACHEOSTOMY (CURRENTLY)
- ☐ CHRONIC LUNG DISEASE

  When: _____
- ☐ USING OXYGEN THERAPY AT HOME?

  How many liters? _____

  ☐ONLY AT NIGHT ☐CONTINUOUS USE
- ☐ EMPHYSEMA
- ☐ COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE)
  - ☐ **I have been hospitalized for COPD in the last year**

ENDOCRINE/AUTOIMMUNE CONDITIONS: *(CHECK ALL THAT APPLY)*

- ☐ LUPUS
- ☐ ANKYLOSING SPONDYLITIS
- ☐ MULTIPLE SCLEROSIS
- ☐ CANCER

  Type: _____

  ☐I currently receive chemotherapy

- ☐ DIABETES

  ☐Type 1 ☐Type 2 ☐ Prediabetes

  ☐I use medication for diabetes

  ☐Oral ☐Insulin Injection

  ☐ Insulin Pump☐GLP-1

STOMACH / LIVER / KIDNEY / INFECTIOUS DISEASE: *(CHECK ALL THAT APPLY)*

- ☐ GASTROESOPHAGEAL REFLUX *(GERD)*
- ☐ LIVER DYSFUNCTION

  Type: _____

- ☐ RENAL DISEASE

  ☐**I undergo dialysis**

- ☐ HEPATITIS
- ☐ HIV INFECTION

BONE / JOINT CONDITIONS: *(CHECK ALL THAT APPLY)*

- ☐ UNABLE TO LIE FLAT
- ☐ SPINAL SURGERY

  When: _____

- ☐ NEUROMUSCULAR DISEASE

  Describe: _____

- ☐ CHRONIC PAIN

  Location: _____

- ☐ MOBILITY LIMITATIONS

  ☐Walker ☐Cane ☐Wheelchair

  ☐Wheelchair Dependent (not able to stand and pivot on my own)

NEUROLOGICAL CONDITIONS: *(CHECK ALL THAT APPLY)*

- ☐ ALTERED MENTAL STATUS
- ☐ DEMENTIA
- ☐ ALZHEIMER'S DISEASE
- ☐ SEIZURES ☐New Onset

  ☐Currently receiving treatment

  ☐Taking Seizure Medication

- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ STROKE/TIA (TRANSIENT ISCHEMIC ATTACK)

  ☐Within 90 Days ☐Within 12 Months