

Physicians Surgery Center Pre-Admission Form

(Please fill this out and bring it with you to your pre-admission interview.)

Patient's Name: _____

Date of Procedure: _____ Age: _____ Height: _____ Weight: _____ lbs.

Surgeon: _____ Type of Surgery: _____

Family Physician: _____

Allergies: _____

Medications you currently take, including over-the-counter medications (For each medication, list name, dose and frequency):

Prior surgeries and date performed: _____

Current and past health problems: _____

Do you have a Living Will or Durable Power of Attorney? Yes No *(If yes, please bring a copy to pre-admission.)*

Do you smoke? Yes No How much a day? _____ Number of Years: _____

Do you drink? Yes No How much? _____ How often? _____

Do you do drugs? Type: _____ How much? _____ How often? _____

Have you or any family member had any problem with anesthesia? Yes No

If so, please indicate the problem and the relation of the family member to the patient. _____

Write down questions that you would like to ask: _____
