

**NAPLES DAY SURGERY, LLC
SELF-ASSESSMENT FORM**

NAME: _____ **DATE:** _____ **AGE:** _____ **SEX:** M _____ F _____

ADDRESS: _____ **HOME PHONE:** _____

SURGEON: _____ **FAMILY PHYSICIAN:** _____ **PHONE:** _____

HEIGHT: _____ **WEIGHT:** _____ **PERMISSION TO LEAVE MESSAGE:** YES _____ NO _____

Routine Daily Medications including appetite suppressants, over-the-counter (dosage and frequency), herbals and vitamins

List all Allergies including Drugs, Tape, Latex, Iodine, Soy Products, food and environmental

Allergy Reactions

History of Disease: Do You Have Any Of The Following:

LUNG	Y	N	VASCULAR	Y	N	SYSTEMIC	Y	N	OTHER	Y	N
Asthma			High Blood Pressure			Diabetic			Smokes		
Emphysema			Heart Attack			Thyroid Trouble			Alcohol Hx		
COPD			Irregular Heart Beat			Fainting			Recent Travel Abroad		
Cough of 3 weeks			MVP of Heart Murmur			Seizure/Epilepsy			Artificial Joints or Grafts		
Shortness of Breath			Hepatitis/Yellow Jaundice			Kidney/Bladder Problems			Problems w/Anesthesia		
TB			Heart Disease/Chest Pain			Hiatal Hernia/Reflux			Family Hx w/Anesthesia		
Other:			Endocarditis			Glaucoma			Pregnant		
			Bleeding Tendencies _____			Mobility			LMP		
			Stroke, TIA, Tingling in Hands And Feet			Breast Surgery			Menopausal		
						Lymph Nodes Excision			Dentures/Partials/Caps		
						Other: _____			Neck Problems		

Please list any major operations and approximate dates:

Reaction to local or general anesthesia or blood relatives with problems: _____ Explain: _____

Who will be taking you home/phone #: _____ / _____

Who will be staying with you the first 24 hours after surgery? _____

Phone number where you will be staying after surgery: _____

Where will you be going to have the following tests done?

LAB/EKG: _____ X-RAYS: _____

PLEASE DO NOT EAT OR DRINK ANYTHING INCLUDING WATER AFTER MIDNIGHT OR YOUR SURGERY WILL BE CANCELLED!

Reviewed by: _____, R.N., N.A.R.

Anesthesia Consult: M.D. _____ Result: _____

Instructions: _____

