

We appreciate you for taking the time to fill out this form.

Patient Info	ormation						
				B:			
Height: Weight: Best Phone Number to Reach You:							
	mber:		- Madical Durable	Dames of Attaura	—Nana	=Other	
•		ctive? Living Will	□ Medicai Durabie	Power of Attorne	y unone	⊔Other	
	rgery Informati		_				
Date of Surge	ery:	Surgeon:	Type o	f Surgery:			
Have you att by ASH? □ Y		class or viewed the av	vailable videos for T	Fotal Joint Replace	ment or Sp	ine surgery offered	
Caregiver I	nformation:						
You must h	nave an adult si	ign for your discha	rge and take vo	u home from tl	he hospit	al	
		Relationship:					
Surgical His	story: Please list a	Il previous surgeries a	nd any complication	ns:			
	•						
	 						
Anesthesia	Screening						
Have you had	d problems w/ and	esthesia in the past?	□ YES □ No				
If yes, describ	be (confusion, von	niting, Malignant Hype	erthermia, delirium):			
		by blood ever had pro			fevers requ	uiring extended	
hospitalization	on, malignant hype	erthermia or sudden d	eath? 🗆 YES	□ No			
Primary Ca	re Provider						
PCP Name		PCP Phone	D	ate of Last Visit			
Specialist P	rovider(s) (Card	liologist, Pulmonol	ogist, etc.)		_		
Specialist Na		Specialist Phone		ate of Last Visit			
		- Срестонност столе					
Recent Dia	gnostic Tests (I	ab work, ECG, X-Ra	v)				
,	ng and Facility:	ab work, LCO, A Na	11				
Date Of Testi	ing and racinty.						



Medication Allergies: □ No □ YES Are you allergic to Latex? □ Yes □ No
If YES, Please list <i>Medication</i> allergies, the reaction you had (ie:hives, rash, blisters, etc) and if the reaction was a mild,
moderate or severe reaction:
Current Level of Activity: □ None (sedentary) □ Light (light housework) □ Moderate (walking) □ Active (biking, hiking) How Often? □Daily □1-2 x/wk □ 3-5 x/wk
Activity Assistance: □ Independent □ Cane /walking stick □ Crutches □ Walker □ Wheelchair
Social History
Tobacco use: Never Former Smoker Current Smoker Smokeless tobacco E Cigs Vaping Age started tobacco: Pack/vapes/pouch/can # per day Age Quit tobacco:
Alcohol use: None# Drinks per Day/Week/Month
Marijuana use: None Edibles/Smoke/Vape/CBD: # per Day/Week/Month Other Substance use (places specific):
Other Substance use (please specify): Who lives at home with you?
Is there Emotional or Physical abuse in your life currently? Yes No
In the past 2 weeks, have you been bothered by feeling down, depressed or hopeless? ☐ YES ☐ No
Immunization History
Pneumonia Vaccination: YES No Date: Flu Vaccination: No YES Date:
Tetanus (Tdap): □ Within 5 years or □ Greater than 5 years COVID Vaccination/booster □ No □ YES
Psychiatric
Anxiety/Panic □ YES □ No Depression □ YES □ No Schizophrenia □ YES □ No
Bipolar Disorder □ YES □ No PTSD □ YES □ No Claustrophobia □ YES □ No
Neurological
Seizures/Epilepsy
Muscle weakness Spinal cord abnormality Spinal cord abnormality No
Dementia/Alzheimer's No Parkinson's Disease YES No Other:
Auto-Immune Disease
Lupus YES No IBS YES No Grave's Disease YES No Multiple Sclerosis YES No No Multiple Sclerosis YES No Other Auto Immuno Disorder
Rheumatoid Arthritis YES No Crohn's Disease YES No Other Auto-Immune Disorder Endocrine
Diabetes (Type I or II)
Diabetes (Type For II) 1 123 1 No Thyroldy Parathyrold Disease 1 123 1 No Other.
Bleeding/ Clotting Disorders
Have you ever had a blood clot in your leg or lung? No PES Date:
Hemophilia No YES Factor V Leiden No YES Other Bleeding/clotting disorder
Family members with bleeding/clotting disorder? No YES



Cardiovascular

High Blood Pressure	□ YES	□ No	Pacemaker/Defibrillator	□ YES □ No	
Valve prolapse	□ YES	□ No	Coronary Artery Bypass Grafts	□ YES □ No	
Palpitations	□ YES	□ No	Heart attack (year)	□ YES □ No	
Stent(s) (year)	□ YES	□ No	High Cholesterol	□ YES □ No	
Chest pain/angina	□ YES	□ No	Irregular Heart Beat	□ YES □ No	
Angioplasty (year)	□ YES	□ No	Rheumatic fever	□ YES □ No	
Congestive heart failure	□ YES	□ No	Heart murmur	□ YES □ No	
Atrial Fibrillation	□ YES	□ No	Other Heart Problems:		
Respiratory					
Have you been tested for Slee	p Apnea?	□ YES	□ No Do you have :	Sleep Apnea? □ YES □ No	
Do you use a CPAP/Bipap? '	YES □ No	If YES:	: With Oxygen # Liters / Witl	nout Oxygen	
Do you use Oxygen? ☐ YES ☐	No	(#)Li	ters Nightly / 24 hours		
Seasonal Allergies/sinusitis	YES □ No) А	STHMA/Wheezing 🗆 YES 🗆 No	Bronchitis/ Chronic cough ☐ YES	□ No
COPD □ YES □ No Emphysem	າa □ YES	□ No	Other Lung Disease		
Gastrointestinal					
	Gastric	Reflux/	'Heartburn □ YES □ No	Hiatal Hernia □ YES □ No	
Kidney/Bladder/Prostate					
•	•				
Enlarged Prostate □ YES □ No) Incon	tinence	□ YES □ No Bladder Issues:		
Musculoskeletal					
Arthritis □ YES □ No Osteo	porosis 🗆	YES 🗆	No Gout 🗆 YES 🗆 No C	urvature of the Spine 🗆 YES 🗆 No	
Back Pain □ YES □ No Deg	generativ	e Joint [Disease □ YES □ No Fibron	nyalgia □YES □No	
Neuropathy (numbness in ext	remity) 🗆	YES □ N	IO Restless Leg syndrome □ Y	ES □ No	
Herniated Disc \square No \square Yes -W	YES				
Other Musculoskeletal Disord	er/ Joint F	Pain:			
Integumentary/Skin					
	n Brou	iacic/ E	czema – VES – No Shingles –	VES II No. Skin Cancer II VES II I	No
Non-healing soles - 125 - W	, 1301	10313/ L	czemia – res – wo – simigies –	TIES - NO SKIII Cancer - TES - I	NO
Cancer					
Cancer □ No □ YES- describe	(Date Dia	agnosed	l, Type, Where in Body)		
	No	□ Yes	(Date)		
•				□ Yes Last Treatment:	



Infectious Disease

Have you ever had MRSA? □ No □ YES Date:	: Where on your body					
HIV/AIDS □ No □ Yes Date Diagnosed:	Last Treatment for AIDS/HIV:					
TB \square YES \square No Treatment Received \square No \square Ye	es Last Treatment for TB:					
Hepatitis □ No □ Yes Type: A□ B□ C□ Date	Diagnosed:Last Treatment:					
C-Diff □ No □ Yes Date Diagnosed:						
COVID-19: Positive test within 30 days □ No	□ Yes Positive test greater than 30 days □ No □ Yes					
Pediatric Information (For Pediatric Patients Only) Premature □ NO □ YES, describe: Developmental delay □ No □ YES, describe:						
Immunizations Current YES No						
Who has Legal custody?	Documentation of Guardianship MUST be submitted					

HOME MEDICATION LIST:

PLEASE LIST ALL PRESCRIPTION MEDICATIONS AND SUPPLEMENTS THAT YOU ARE **CURRENTLY** TAKING

Medication Name	Dose (mg)	Frequency (am, pm, as needed)	Reason you take this medication	
				L
				-
				_
Your Preferred Pharmacy:		Pharmacy Phone #:		
Dev. 6/20/2022				