MORRIS COUNTY
Surgical Center

Preoperative patient questionnaire
Morris County Surgical Center

Please answer the following questions about your medical and anesthesia history before your scheduled endoscopy procedure at Morris County Surgery Center. **If you answer Yes to any of the questions,** please call the surgery center immediately at **973-265-7200,** and ask to speak with a preoperative nurse for further evaluation. You ***must*** contact us before your procedure date to avoid a delay or cancellation of your procedure due to concerns about your past medical- anesthesia history.

Preoperative conditions Requiring immediate evaluation and reporting to Morris County surgical center.

1- Have you or a close relative ever had a problem with anesthesia other than nausea? YES__ NO__
If yes please explain_____
_____

2- (Female)Do you weigh more than 250 pounds? Yes ___ NO___
3- (Male) Do you weigh more than 270 pounds? Yes ___ NO___

4- Do you have obstructive sleep apnea. YES__ NO__

5- Do you have breathing difficulty such as severe Asthma, COPD, Emphysema and do you use supplemental Oxygen at home to help you breath? Yes__ No__

6- If you climb 2 flights of stairs, do you become short of breath Yes__ No__ or experience chest pain? Yes__ No__

7- Do you have a history of Angina, Heart disease, Heart attack or Irregular heartbeat? Yes__ No__

8- Do you have an implanted AICD or automatic implantable cardioverter defibrillator? Yes__ No__

9- Have you had surgery on the spine in your neck? Yes___ No___** *Nothing to eat or drink after midnight the night before your procedure* ***EXCEPT:*** *If you take Blood Pressure medication, please take your morning dose with a tiny sip of water.*
** *Bring Your Insurance card and photo ID.*
** *Leave all valuables/jewelry at home*
****** **You must have a responsible adult to drive you to and from the center on the day of your procedure******

Thank you for taking the time to answer these important questions and please contact us immediately if you answer yes to any of the above questions.

Reviewed by:

RN Signature:_____ Anesthesiologist:_____

Please bring to facility Day of procedure!

Morris County Surgical Center, LLC 3695 Hill Road Parsippany, NJ 07054 Phone: 973-265-7200 Fax: 973-265-7222	Patient Name:	DOB: MRN: DOS: Dr.:

Medication Reconciliation Form

Allergies/Reactions: *(List all including reactions.)*

□ NKA

Medications Being Taken Prior to Admission: (List all medications, OTC drugs, and herbal supplements.)

□ Patient takes no medications, OTC drugs, or herbal supplements on a routine basis.

Medication (Check box if taken day of surgery.)	Dose	Frequency	Indication (Reason)
□			
□			
□			
□			
□			
□			
□			
□			
□			
□			
□			
□			

Source of Information: □ Patient □ Family Member □ Medication List

Information Obtained By: _____ RN Date: _____ Time: _____ am/pm

Attestation: I verify that the above list of medication(s) is complete and accurate to the best of my knowledge. This list includes any over the counter medications and herbal supplements, as well as regular and occasionally used prescription drugs. I am aware that my physician is resuming the start of my medications after surgery based on the information provided my be, including the name of the medications, dosages, and frequency.

_____ _____ _____

Patient Signature Parent/Guardian/Representative Date

Medications Post Surgery/Procedure

You **may safely resume** taking all of the above medications, over the counter medications and herbal supplements prescribed by your physician(s).
For exceptions to this see below:

Medication	Dose	Frequency	Resume Medication (Date and Time)

The following **new medications** have been prescribed for you:

Medication	Dose	Frequency	Next Dose (Date and Time)

Physician's Signature: _____ ***RN's Signature:*** _____

Morris County Surgical Center, LLC
3695 Hill Road
Parsippany, NJ 07054
Phone: 973-265-7200
Fax: 973-265-7222

Patient Sticker

Pre-Admission Interview

Allergies/Reactions: □Yes □ NO

Please list any allergies and reaction:

Surgery Information:

Procedure: □**COLONOSCOPY** □**EGD**

Previous Hospitalizations and/or Surgical History:

Primary Language: □ **English** □ **Other:**_____ **Translator Needed:** □ **Yes** □ **No**

Medical History (*Check all that apply*):

Medical Physician: _____

Height: _____ Weight: _____ (office Use)BMI: _____

Cardiac/Circulatory _____ □Yes □ NO

□ Defibrillator/ Pacemaker □ Irregular Heartbeat
□ High Cholesterol □ Heart Attacks
□ Hypertension □ Heart Murmur

Respiratory _____ □Yes □ NO

□ Asthma □ COPD □ Emphysema □ TB
last episode:_____ □ Shortness of Breath
□ Pneumonia □ Sleep Apnea □ Pulmonary Embolus
□ Chronic Cough

Endocrine _____ □Yes □ NO

□ Diabetes □ Thyroid Disease

Gastrointestinal □Yes □ NO

□ IBS/Chron's □ Diarrhea □Hiatal Hernia □ GERD
□ Diverticulitis □ Constipation □ GI Bleeding
□ Liver Disease □ Hepatitis A B C □ GI Ulcer
□ Hemorrhoids

Genitourinary _____ □Yes □ NO

□ Incontinence □ Renal Failure □ Retention
□ Kidney Stones □ UTIs □ Enlarged Prostate

Musculoskeletal _____ □Yes □ NO

□ Arthritis □ Chronic Pain □ Osteoporosis
□ Spinal/Disc Disease □ Autoimmune Disorders

Neurological/Mental Health □Yes □ NO □ Neuropathy

□ Seizures/Epilepsy □ Depression □ Syncope
□ CVA/Strokes □ Paralysis □ TIA □ Anxiety
□ Psychiatric Illness □ Headaches/Migraines
□ Glaucoma

Cancer _____ □Yes □ NO Type_____

Do you take blood thinners or Aspirin? □Yes □ NO

When did you stop taking them? _____

TEETH: □ Intact □ Capped (Permanent/Temporary)
□ Dentures □ Loose
□ Prosthetics: _____ □ Other: _____

Special: Religious or Cultural Needs: □ No □ Yes _____
Learning Needs: □ No □ Yes _____
Nutritional Needs: □ No □ Yes _____
Physical Disabilities: □ No □ Yes _____

Race/Religion _____/_____

Alcohol Use: □ **No** □ **Yes** **Tobacco Use:** □ **No** □ **Yes**
Recreational Drug Use: □No □ Yes

Recent Exposure to Communicable Disease: □ No □ Yes
Have you ever been treated for a drug resistant organism? □ No □ Yes

RECENT TRAVEL HISTORY? □**Yes** □ **NO** Where? ___When?____

Concerns Related to Current Surgery/Procedure: □ No □ Yes _____
Family/Other Type of Support System Available: □ Yes □ No
Emergency Contact Name/Phone Number:_____

Pre Admission Tests: FOR OFFICE USE:

If Pre-Admission testing was ordered please indicate below: □ N/A □Yes

History and Physical (circle): Received Pending

Reviewed by RN:_____ Date_____

Reviewed by Anesthesiologist: _____ **Date:**_____

Pre-Op Instructions: □ **Reviewed with patient**

Bring the following with you to the center:

1) insurance card(s) & photo ID
2) copy of Advance Directive or Living Will if applicable
3) list of current medications with dosages
4) inhalers for asthmatic patients
5) assistive devices (braces, crutches, ect.)

Do not wear:

1) contact lenses
2) heavy makeup
3) jewelry ***Leave all jewelry and valuables at home**
4) remove body piercings

Medication Requirements:

Patients please take your Blood Presure medication (with a small sip of water) in the AM prior to surgery except stand alone diuretics and oral hypoglycemics.

Avoid: No Smoking for 24 hours prior to procedure if applicable

**Nothing to eat Or drink after Midnight the night before your procedure (except for the prep if you are having a Colonoscopy)

All patients must have a responsible adult to drive them to and from the center on the day of surgery.