Surgical Patient Pre-Operative Medical History

PRECISION SURGERY CENTER OF NAPA VALLEY

PLEASE PRINT

Patient Name (Last, First)			Date of Surgery/Procedure
( )	( )		
Patient Phone No.	Patient Alternate Phone No.	Patient E-Mail	
	' "	lbs.	Female Male
Patient Date of Birth (MM/DD/YYYY)	Patient Height	Patient Weight	Patient Sex

John Bosetti, MD Allison Hinko, MD Nancy Jameson, MD David Kim, MD

Yungtai Kung, MD Mohit Mehtani, MD Paul Row, MD Rona Silkiss, MD

Who is your surgeon?

Is anyone helping you, the patient, complete this form? Yes No

Is the person completing this form your designate agent or Durable Power of Attorney? Yes No

If yes, what is the agent's name? _____

What is the agent's phone no.? _____

Will your designated agent/DPA accompany you on the day of your procedure? Yes No

It is helpful to have Power of Attorney documentation prior to the day surgery day, but it must be available no later than the time of arrival on surgery day. If the DPA document and agent are unavailable, the surgery will be rescheduled.

General Questions

1. Are you claustrophobic or do you have trouble lying flat? Yes No
   If yes, explain _____
2. Have you experienced a runny nose, tearing, sneezing, or itching after:
   - A dental or internal exam? Yes No
   - Blowing up balloons? Yes No
   - Coming into contact with rubber gloves or products? Yes No
   - The use of condoms or a diaphragm? Yes No
   - Eating bananas, avocados, water chestnuts, kiwi? Yes No
3. Have you or anyone in your family had a history of problems with anesthesia/sedation/analgesia? Yes No
   If yes, describe _____
4. Do you have a history of emotional problems? Yes No
5. Do you use alcohol? Yes No
   If yes, provide the number of glasses/servings: _____ day / week / month
6. Do you have a history of smoking, e-cigarettes, vaping, or other tobacco use? Yes No
   If yes, for how many years? _____ Amt/Day: _____ Former User/Quit Current User
7. Do you have any mobility issues? Yes No
   If yes, explain _____
8. Do you feel safe in your home/living environment? Yes No
9. Is there a chance you may be pregnant? Yes No
10. Have you had the COVID-19 vaccination? Yes No
    If yes, how many doses? _____

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Past Medical History	YES	NO
Hyperlipidemia		
Hypertension		
MI		
MVP / Heart Murmur / Heart Valve Replacement		
Palpitations / Arrythmias / Atrial Fib / Chest Pain		
Pacemaker / AICD		
Asthma / SOB / Home O_2 / COPD		
Sleep Apnea / CPAP / BiPAP		
Tuberculosis		
Stroke / TIA		
Seizure Disorder		
Diabetes		
Thyroid Disorder		
Bleeding Disorder		
Kidney Disorder / On Dialysis		
Hepatitis / Liver Disorder		
Esophageal Stricture / Dysphagia		
Hiatal hernia / Ulcer / Motion Sickness / GERD		
Cancer / Location: _____		
Exposure to Infectious Disease / AIDS / Herpes / STDs / MRSA / VRE		
Recent Influenza (flu) or Other Infection		
Arthritis		
Vision Disorder / Glaucoma / Hearing Loss / Hearing Aid		

Medical Allergies Latex Allergy

Allergy	Reaction

Past Surgical History	Date		Date

Other Medical Information/Issues

Is there anything else you would like our staff or the anesthesia team to know?

By signing below, I indicate that the information provided is current and accurate. I agree to update the staff of Precision Surgery Center of Napa Valley if there are any changes to the information provided before the date of your procedure.

Signature of Patient or Legal Guardian* Date Time

*Legal guardians/health care agents must provide a copy of a Durable Power of Attorney (DPA) with this document which indicates the authority to sign on behalf of the patient. This person should also accompany the patient on the day of the procedure/surgery to sign consents and other documents.