AOC PATIENT QUESTIONNAIRE / ASC HISTORY

MR#: _____ Date: _____ Name: _____

Sex: [M] [F] DOB: _____ Age: _____ Weight: _____ Height: _____

Family / PCP Dr. name: _____ Other relevant specialists / Drs.: _____

Workers' comp or other 3rd parties needing your records: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Pref. language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ White / Caucasian ☐ African American ☐ Am. Indian / Alaskan ☐ Asian ☐ Hawaiian / P. Islander ☐ Other: _____

CHIEF COMPLAINT:

What is the main reason for your visit?: _____

How long have you had this problem?: _____

REVIEW OF SYSTEMS: Check to indicate the symptoms you are experiencing today.

- [Y] [N] Fever / night sweats / weight loss
- [Y] [N] Skin rash / itching
- [Y] [N] Ringing in the ears
- [Y] [N] Dry skin
- [Y] [N] Throat problems
- [Y] [N] Urinary problems
- [Y] [N] Swollen joints
- [Y] [N] Hearing loss
- [Y] [N] Confusion / depression
- [Y] [N] Shortness of breath
- [Y] [N] Allergic / immune problems
- [Y] [N] Visual disturbances
- [Y] [N] Balance problems / tremors / dizziness
- [Y] [N] Chest pain
- [Y] [N] Bleed or bruise easily
- [Y] [N] Nasal problems
- [Y] [N] Heartburn / nausea / vomiting
- [Y] [N] Abdominal pain

PAST MEDICAL HISTORY: Please indicate ([A] active, [H] history, [N] none) to each condition.

VASCULAR
- [A] [H] [N] High blood pressure
- [A] [H] [N] Heart attack / *date*: _____
- [A] [H] [N] Heart rhythm problems
- [A] [H] [N] Mitral valve prolapse
- [A] [H] [N] Congestive heart failure
- [A] [H] [N] Cardiac septal defects
- [A] [H] [N] Vascular disease
- [A] [H] [N] Rheumatic fever
- [A] [H] [N] Stroke or TIAs / *date*: _____
- [A] [H] [N] Anemia
- [A] [H] [N] Deep vein thrombosis / *date*: _____

Other: _____

GI
- [A] [H] [N] Ulcers
- [A] [H] [N] GERD (reflux)
- [A] [H] [N] Cirrhosis of liver
- [A] [H] [N] Hepatitis [A] [B] [C]
- [A] [H] [N] Hiatal hernia

Other: _____

ENDOCRINE
- [A] [H] [N] Diabetes Type 1
- [A] [H] [N] Diabetes Type 2
- [A] [H] [N] Hypothyroid
- [A] [H] [N] Hyperthyroid

Other: _____

RESPIRATORY
- [A] [H] [N] Sleep apnea
  - *sleep study date*: _____
  - *doctor*: _____
- [A] [H] [N] CPAP use
- [A] [H] [N] Pneumonia / *date*: _____
- [A] [H] [N] Asthma
- [A] [H] [N] Home oxygen
- [A] [H] [N] Tuberculosis (TB)
- [A] [H] [N] Emphysema
- [A] [H] [N] COPD
- [A] [H] [N] Tracheal stenosis

Other: _____

CANCER
- [A] [H] [N] Head and/or neck / *date*: _____
- [A] [H] [N] Skin / *date*: _____
- [A] [H] [N] Lung / *date*: _____
- [A] [H] [N] Colon / *date*: _____
- [A] [H] [N] Prostate / *date*: _____
- [A] [H] [N] Breast / *date*: _____
- [A] [H] [N] Lymphoma / *date*: _____
- [A] [H] [N] Radiation / *date*: _____
- [A] [H] [N] Chemotherapy / *date*: _____

Other: _____

MUSCULOSKELETAL
- [A] [H] [N] Degenerative arthritis
- [A] [H] [N] Rheumatoid arthritis

Other: _____

RENAL
- [A] [H] [N] Renal failure
- [A] [H] [N] Kidney stones
- [A] [H] [N] BPH

Other: _____

ANESTHESIA/SURGERY RELATED
- [A] [H] [N] Malignant hyperthermia
- [A] [H] [N] Latex allergy
- [A] [H] [N] Bleeding problems
- [A] [H] [N] Failure to thrive — pediatric
- [A] [H] [N] Pseudocholinesterase def

Other: _____

OTHER
- [A] [H] [N] Glaucoma
- [A] [H] [N] Seizures
- [A] [H] [N] Noise exposure
- [A] [H] [N] Migraines
- [A] [H] [N] HIV/AIDS
- [A] [H] [N] Fibromyalgia

Please list any other **SERIOUS** medical problems: _____

PAST SURGICAL HISTORY:

Have you ever had surgery? Y N — Please check all that apply to you. If yes, indicate approximate date.

CARDIOTHORACIC
- ☐ CABG / *date*: _____
- ☐ Stent placement / *date*: _____
- ☐ Pacemaker / *date*: _____
- ☐ Defibrillator / *date*: _____
- ☐ Valve replacement / *date*: _____
- ☐ Carotid endarterectomy / *date*: _____
- ☐ Lung surgery / *date*: _____

Other: _____

GI
- ☐ Gastric bypass / *date*: _____
- ☐ Gall bladder / *date*: _____
- ☐ Hiatal hernia repair / *date*: _____
- ☐ Appendectomy / *date*: _____

Other: _____

ENT
- ☐ Ear surgery / *date*: _____
- ☐ Ear tubes / *date*: _____
- ☐ Tonsillectomy / *date*: _____
- ☐ Adenoidectomy / *date*: _____
- ☐ Sinus surgery / *date*: _____
- ☐ Nasal surgery / *date*: _____
- ☐ Tracheal surgery / *date*: _____
- ☐ Laryngeal surgery / *date*: _____
- ☐ Thyroid surgery / *date*: _____
- ☐ Throat surgery / *date*: _____

Other: _____

ORTHOPEDIC
- ☐ Knee replacement / *date*: _____
- ☐ Hip replacement / *date*: _____
- ☐ Neck spine surgery / *date*: _____
- ☐ Back surgery / *date*: _____

Other: _____

OTHER SURGERY
- ☐ Craniotomy / *date*: _____
- ☐ Cancer surgery / *date*: _____
- ☐ Tubal ligation / *date*: _____
- ☐ Hysterectomy / *date*: _____
- ☐ EGD / *date*: _____
- ☐ Aortic aneurysm / *date*: _____

Other: _____

Y N Have you had previous problems with ANESTHESIA? Describe: _____
Y N Do you BRUISE easily or BLEED excessively when cut? Describe: _____
Y N Have you ever had a SLEEP STUDY? Date tested? _____ Study DOCTOR? _____
Y N Have you ever had a COLONOSCOPY? Date tested? _____

FOR FEMALE PATIENTS ONLY:

Y N Are you pregnant? Y N Using birth control? Y N Breast feeding?
Y N Have you had a mammogram? / Date of your last mammogram: _____

ALLERGIES: Please check **ALL** allergies you have and describe your reaction.

- ☐ **None, I have NO allergies**
- ☐ Acetaminophen: _____
- ☐ Aspirin: _____
- ☐ Cephalosporin: _____
- ☐ Codeine: _____
- ☐ Demerol: _____
- ☐ Erythromycin: _____
- ☐ Hydrocodone: _____
- ☐ Ibuprofen: _____
- ☐ Iodine: _____
- ☐ Morphine: _____
- ☐ Penicillin: _____
- ☐ Sulfonamides: _____
- ☐ Tetracycline: _____
- ☐ Latex allergy: _____
- ☐ Shellfish: _____
- ☐ X-ray dye (iodine): _____
- ☐ Other (describe): _____

Have you had **ALLERGY** testing? Y N When?: _____ Name of allergy Dr.: _____
List what was positive: _____

MEDICATIONS: Do you take **ANY** medications? Y N — List all current **prescription** and **over-the-counter** medications.

Medication name	Dosage / frequency	Reason for taking	How long have you taken?

Are you taking any supplements or herbal medications? Y N — Please check all that apply to you.
- ☐ Vitamin E
- ☐ Garlic
- ☐ Ginger
- ☐ St. John's wort
- ☐ Ginkgo biloba
- ☐ Ginseng
- ☐ Feverfew
- ☐ Fish oil / Omega 3
- ☐ Other _____
- ☐ Multivitamin
- ☐ Vitamin B12

SOCIAL HISTORY:

Smoking status:

- ☐ Current **every day** smoker / age started: _____
- ☐ Current **occasional** smoker / age started: _____
- ☐ Former smoker / age quit: _____ / quit date if less than a year ago: _____
- ☐ Never smoked

Tobacco type used:

- ☐ Cigarettes
- ☐ Cigars
- ☐ Pipe
- ☐ Smokeless tobacco

☐Y ☐N Have you had smoking cessation counseling?

☐Y ☐N Do you use alcohol? How often? / How much?: _____

☐Y ☐N Do you use recreational drugs? Which ones?: _____

☐Y ☐N Do you wear a hearing aid(s)? ☐ Right ear and/or ☐ Left ear

What is your occupation? (If retired, list former occupation) _____

FAMILY HISTORY:

☐Y ☐N Are you married?

Do you have a family history of:

☐Y ☐N Hearing loss	☐ Parent	☐ Sibling	☐ Child	☐ Other: _____
☐Y ☐N Malignant hyperthermia	☐ Parent	☐ Sibling	☐ Child	☐ Other: _____
☐Y ☐N Muscle disease	☐ Parent	☐ Sibling	☐ Child	☐ Other: _____
☐Y ☐N Cancer	☐ Parent	☐ Sibling	☐ Child	☐ Other: _____
☐Y ☐N Diabetes	☐ Parent	☐ Sibling	☐ Child	☐ Other: _____
☐Y ☐N Heart disease	☐ Parent	☐ Sibling	☐ Child	☐ Other: _____
☐Y ☐N Anesthesia complications	☐ Parent	☐ Sibling	☐ Child	☐ Other: _____
☐Y ☐N Bleeding disorder	☐ Parent	☐ Sibling	☐ Child	☐ Other: _____

PEDIATRIC HISTORY: For patients 0-12 years old ONLY.

Birth weight: _____ lbs. _____ ozs.

☐Y ☐N Was birth via C-section? _____

☐Y ☐N Premature? _____

☐Y ☐N Problems with pregnancy? _____

☐Y ☐N Problems at birth? _____

☐Y ☐N Apnea? _____

☐Y ☐N Monitored? _____

☐Y ☐N Failed newborn hearing screening? _____

FOLLOWING BLANKS ARE FOR PHYSICIAN COMPLETION ONLY:

Reviewed by physician: _____ Date: _____
(signature)

Questionnaire must be reviewed and updated by physician within 30 days — PRIOR to surgery date.

Reviewed and updated by physician: _____ Date: _____
(signature)