Copper Queen Community Hospital

**Palominas RHC**

10524 E. Hwy 92, Palominas, AZ 85615

Phone: 520-366-0300

Fax: 520-366-9841

**Suzanne Daly, MD Vinod Singh, MD Aaron Patton, PA-C**

**Gastroenterology New Patient Paperwork**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: S M D W Number of Children:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we contact you via email with results? ☐ Yes ☐ No

Employed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long? \_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any person(s) we are allowed to speak with regarding your medical information:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly state the reason you are here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications? ☐ No ☐ Yes, please list below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to : ☐ Milk ☐ Soy ☐ Eggs ☐None

Do you drink alcohol: ☐ No ☐ Yes, How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Quit? When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? ☐ No ☐ Yes, How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Former Smoker** Quit when? \_\_\_\_\_\_\_\_\_\_\_

Electronic Cigarette: ☐ No ☐ Yes, How much? \_\_\_\_\_\_\_\_\_\_\_ **Former Smoker** Quit when? \_\_\_\_\_\_\_\_\_\_\_­

Recreational Drugs: ☐ No ☐ Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all medications( Prescription, over the counter, vitamins, or herbs that you are currently taking) including dosage and frequency.**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Frequency** |
|  |  |  |
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**Previous Surgical History(Please include year)**

Gallbladder/Cholecystectomy\_\_\_\_\_\_\_\_ Hysterectomy\_\_\_\_\_\_\_\_ Appendix/Appendectomy\_\_\_\_\_\_\_\_

Heart Surgery(Type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Colon/Bowel\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History(Please check all that apply)**

☐ **Prior Colonoscopy:** When?\_\_\_\_\_\_\_ Findings: ☐Colon Polyps ☐Colon Cancer ☐ Other\_\_\_\_\_\_\_\_\_\_\_

☐ **Prior Upper Endoscopy:** When? \_\_\_\_\_\_\_\_ Findings: ☐ IBS ☐ Ulcers(Where\_\_\_\_\_\_\_\_\_\_\_)

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Liver Disease:** What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Cancer of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Crohn’s Disease ☐ Heartburn ☐ Ulcerative Colitis ☐ Anemia

☐ Diverticular Disease ☐ Mouth Sores ☐ High Blood Pressure ☐ Diabetes

☐ Yellow skin/eyes( Jaundice) ☐ Arthritis ☐ Kidney Disease ☐ Swollen Ankle/Feet

☐ Thyroid Disease: ☐ Hyper ☐ Hypo ☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mark all that apply:**

Heart Problems ☐ No ☐ Yes Lung Problems ☐ No ☐ Yes

Chest Pain/Angina ☐ No ☐ Yes How often?\_\_\_\_\_ Emphysema/COPD ☐ No ☐ Yes

Heart Failure ☐ No ☐ Yes CPAP/O2 ☐ No ☐ Yes

Afib/Pacemaker ☐ No ☐ Yes Shortness of Breath ☐ No ☐ Yes

Arrhythmias ☐ No ☐ Yes Asthma/Wheezing ☐ No ☐ Yes

Low Blood Sugar ☐ No ☐ Yes Seizure/Convulsions ☐ No ☐ Yes

Nerve Damage ☐ No ☐ Yes Paralysis ☐ No ☐ Yes

Stroke ☐ No ☐ Yes Anxiety/Depression ☐ No ☐ Yes

Stress level ☐ Low ☐ Moderate ☐ High

**Please mark any recent digestive symptoms that apply:**

☐ Abdominal Pain ☐ Heartburn ☐ Acid Reflux ☐Nausea ☐ Vomiting ☐ Change in bowel habits

☐ Diarrhea ☐ Constipation ☐ Blood in stool ☐ Rectal bleeding ☐ Weight gain \_\_\_\_\_\_lbs

☐ Weight loss \_\_\_\_\_lbs ☐ Hemorrhoids( ☐Internal ☐ External) ☐ Trouble swallowing

**Family History:** ☐ Mark here is unknown.

Father: ☐ Alive: Age\_\_\_\_\_ ☐ Deceased: Age\_\_\_\_\_ Cause of death:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: ☐ Alive: Age\_\_\_\_\_ ☐ Deceased: Age\_\_\_\_\_ Cause of death:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Family Health History** | **Maternal Side /Relationship** | **Paternal Side /Relationship** |
| Colon Polyps |  |  |
| Ulcerative Colitis |  |  |
| Liver Disease |  |  |
| Diabetes |  |  |
| Colon Cancer |  |  |
| Gastric Cancer |  |  |
| Gallstones |  |  |
| Chron’s |  |  |
| IBS/ What kind |  |  |
| Pancreatitis |  |  |
| Ovarian/ Endometrial Cancer |  |  |
| Other Cancer/ What kind |  |  |

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**Pre-Anesthesia Testing Questionnaire**

This form is to provide the safest care possible; these questions are required by our Anesthesia Department. Please take a moment and complete as accurately as you can. Thank you for letting us care for you!

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Name | Date of Birth | Age | Height | Weight |

|  |  |  |
| --- | --- | --- |
| Proposed Surgery | Medication Allergies (Please list): | Egg Allergy  **YES NO** |

List all supplements and over the counter pills you take:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all surgeries that you have had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Steroid use for more than 6 months? ☐ No ☐ Yes Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an infection now? ☐ No ☐ Yes Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a serious staph/MRSA infection ☐ No ☐ Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had issues with anesthesia? ☐ No ☐ Yes

Have you ever been told you are difficult to intubate? ☐ No ☐ Yes

Have any family members had other problems with anesthesia? ☐ No ☐ Yes

Have you had a high fever with anesthesia (Malignant Hyperthermia)? ☐ No ☐ Yes

Has any family members had a high fever with anesthesia (Malignant Hyperthermia)? ☐ No ☐ Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of person completing form Date