BUFFALO AMBULATORY
SURGERY CENTER
3095 Harlem Road · Cheektowaga, New York 14225
P: 716.896.3815 · F: 716.896.3015

Surgery Center Staff:
Place Patient Sticker Here

Personal Health History / Patient Self Assessment: PLEASE COMPLETE PROMPTLY

Patient Name	**Date of Birth**

When you arrive home you should have a responsible adult remain with you for assistance. Please list their name and phone number below.

Name: **Phone Number:**

☐ **Please mail this form to the Center as soon as possible** ☐ **Filled out online at www.simpleadmit.com password BUFF123NEW**	**Phone Number that is best to reach you at:**
Date of surgery:	**Surgeon:**
What procedure/site are you scheduled for?	**Medical Doctor:** **Dr. Telephone Number:** **Date of Appointment for History and Physical exam:**

If you need a hearing or language interpreter, please call our office at 896-3815 (1) week in advance.

What is your Primary Language ☐ **English** ☐ **Other:**

List allergies and Sensitivities ☐ See Attached List (*include medication and food*):	**Are you allergic to Latex (rubber)?** ☐ No ☐ Yes/ **please describe reaction:** **Please call the Surgery Center if you responded YES to this question.**
List medications dosage, frequency & herbal medications ☐ See Attached List (*include Prescription eye drops, and Vitamins*)	**Do you take aspirin or blood thinners?** ☐ No ☐ Yes /name:_____ **Have you been instructed to stop your blood thinners prior to surgery**? ☐ No ☐ Yes **If YES, when was your last dose?** _____ Comments:
	Do you need any assistance with walking? ☐ No ☐ Yes **Do you use a:** ☐ Walker ☐ Wheelchair ☐ Cane **Have you had a fall within the last year**? ☐ No ☐ Yes When? _____ **Did you sustain any fracture from this fall:** ☐ No ☐ Yes

Do you have any of the following conditions?

☐ **Breathing Problems**	☐ **Heart Problems:** ☐ Heart attack When?

☐ Asthma ☐ Emphysema ☐ shortness of breath ☐ COPD ☐ Other **Do you wear oxygen?** ☐ No ☐ Yes How many liters and how often? _____ Do you have **Sleep Apnea:** ☐ ☐ **Do you use a CPAP machine**?	_____ ☐ Implantable defibrillator/ICD When? _____ ☐ Cardiac Pacemaker When? _____ ☐ High Blood Pressure ☐ Chest pain/ Angina How often? _____ ☐ History of Strokes: _____ ☐ TIA (Mini Stroke) When? _____ ☐ Bleeding Problems ☐ Other:
☐ **Gastro-intestinal Problems** ☐ **Hiatal Hernia ☐ Difficulty Swallowing** ☐ **GERD** (Reflux) ☐ **Other:**	☐ **Diabetes** ☐ Insulin Dependent ☐ Insulin pump ☐ Oral Medication ☐ Diet Controlled **Thyroid** ☐ Hypo ☐ Hyper
☐ **Cancer:** **Where:** **When:**	☐ **Arthritis:**
☐ **Kidney Disease** ☐ **Dialysis** / What is your schedule:_____ ☐ **Hepatitis**	☐ **Seizure Disorder**: Date of Last seizure:
☐ **Other:**	
Do you have any open wounds on your body? ☐ No ☐ Yes If Yes, where located:	
Do you have a history of MRSA or other communicable diseases? ☐ **No** ☐ **Yes**	
Have you recently been ill with a cold, fever or flu? ☐ No ☐ Yes	
Your Height: **Weight:**	
Females Only Could you be pregnant? ☐ No ☐ Yes **Date of your last menstrual period**:	
Have you ever had surgery before? ☐ No ☐ Yes (List surgery/ dates)	
Have you or any members of your family had any problems connected with anesthesia or operations? ☐ No ☐ Yes If YES, explain: Do you have motion Sickness? ☐ No ☐ Yes	
Have you been hospitalized for any reason in the past year? ☐ No ☐ Yes **If YES**, please specify:	
Do you drink alcohol daily? ☐ No ☐ Yes If YES, how much?	
Do you smoke cigarettes? ☐ No ☐ Yes If YES, how much	
Do you use recreational drugs? ☐ No ☐ Yes / explain:	
Do you have transportation on the day of your surgery? ☐ Yes ☐ No *If **NO** please contact the surgery center as soon as possible*	

Discharge Reminder: **following your surgery you may need someone available at home to help you with your care.**

_____

Signature of Patient (*or Responsible Adult*) **completing form**

If not completed by patient, this form was completed by: ☐ Relative ☐ Friend ☐ Other

Reason*:*_____

Relationship: **Daytime Phone Number:**

If this patient is unable to sign for themselves do they have a Healthcare / Medical POA responsible for patient consent ?

(*Name of person*)_____

Relationship: **Daytime Phone Number:**

▼ Surgery Center Use ▼

☐ **Local** no testing required

☐ **Nursing Review / Signature: _____**

Date:_____

Notes