Salisbury Uro Surgical Center LLC
Ambulatory Surgical Center Pre Assessment Questionnaire

Patient's Name: _____ Social Security # _____ Date: _____

- Please list all medications, prescribed, over the counter and herbal supplements.

_____

_____

_____

_____

_____

_____

- Are you allergic to any drugs or foods, if so please list.

_____

_____

- Past Medical History: _____

_____

_____

_____

- Do you have a latex allergy? Yes No
- Do you have a pacemaker? Yes No
- Do you have any breathing problems? Yes No Explain: _____
- Did you have any joint replacements? Yes No Explain: _____
- Did you have any heart surgery? Yes No Explain: _____
- Do you bruise or bleed easily? Yes No
- Do you get urinary tract infections frequently? Yes No Explain: _____
- Do you have a history of kidney stones? Yes No
- Do you every see blood in your urine? Yes No
- Do you have difficulty urinating? Yes No
- Do you have pain when you urinate? Yes No
- Any reaction to local or general anesthesia? Yes No Explain: _____
- History of smoking? Yes No Year quit _____ packs/years _____
- Drink alcohol/beer? Yes No Amount _____ in past 24 hours _____
- WOMEN ONLY: Is there any possibility you could be pregnant? Yes No