

The Surgery Center of Farmington  
400 Parkland Drive  
Farmington, MO 63640

**PREOPERATIVE NURSES ASSESSMENT**

**ASSESSMENT:**  PER PHONE  SURGERY CENTER/ **REFERRING DR.** \_\_\_\_\_

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ BY: \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**LATEX ALLERGY:**  YES  NO HT: \_\_\_\_\_ WT: \_\_\_\_\_

CHIEF COMPLAINT/SURGICAL SITE: \_\_\_\_\_

SURGICAL HX/HOSPITALIZATION: \_\_\_\_\_

ALCOHOL USE:  NO  YES, How much per day: \_\_\_\_\_

TOBACCO USE:  NO  YES, How much and how long: \_\_\_\_\_

P.O.A.:  No  Yes, \_\_\_\_\_

HOME  
MEDICATIONS: \_\_\_\_\_

BLOOD THINNERS: Coumadin, Plavix, ASA, etc:  NO,  YES: \_\_\_\_\_  
Last day took blood thinners: \_\_\_\_\_

<input type="checkbox"/> Glasses/contacts	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Total joint replacement: _____
<input type="checkbox"/> Dentures	<input type="checkbox"/> Asthma	<input type="checkbox"/> MI _____	<input type="checkbox"/> Stents: _____
<input type="checkbox"/> Skin Condition	<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Valves: _____
<input type="checkbox"/> Cataract/Glaucoma	<input type="checkbox"/> Hx of Pneumonia	<input type="checkbox"/> Pacemaker: _____	<input type="checkbox"/> MVP: _____
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hx of Seizures	<input type="checkbox"/> C-PAP or O2 _____
<input type="checkbox"/> Esophageal Stricture	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Hx of Strokes: _____	<input type="checkbox"/> Hx of Kidney Disease: _____
<input type="checkbox"/> Esophageal Reflux	<input type="checkbox"/> Hx of Cancer: _____	<input type="checkbox"/> Hx of Rheumatic Fever	<input type="checkbox"/> Dialysis: Last time: _____
<input type="checkbox"/> Hx of Head Injuries	<input type="checkbox"/> Fm Hx of Cancer: _____	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Arthritis		<input type="checkbox"/> IDDM / <input type="checkbox"/> NIDDM	
<input type="checkbox"/> Ambulatory Aides	<input type="checkbox"/> L.M.P: _____	<input type="checkbox"/> Pre-Op Lab work: _____	

**Pre-Op Teaching Nurses Notes**

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