SOUTHGATE
SURGICAL SUITES

PT DEMOGRAPHICS

NAME _____
DOB _____
AHC# _____

PRE-OP ASSESMENT

FAX or EMAIL completed form:
F 403-942-6779
E southgatesurgicaloffice@gmail.com

DATE _____
FAMILY DR _____
CLINIC _____

ALLERGIES	Y	N	rxn	MEDICATIONS
Medication	☐	☐	_____	☐ List attached
Latex	☐	☐	_____	_____
Food	☐	☐	_____	_____

PRE OP ORDERS	Y	N	Pending	Tests Ordered
	☐	☐	☐	☐ _____

HISTORY ☐ see attached

Surgical_____ Medical_____

_____ _____

_____ _____

_____ _____

_____ _____

	Y	N
Smoking	☐	☐
Alcohol	☐	☐
Recreational Drugs	☐	☐
Adverse rxn to anesthetics	☐	☐
Family Hx rxn to anesthetics	☐	☐

PHYSICAL EXAMINATION

	Normal	Abnormal
ENT _____	☐	☐
Resp _____	☐	☐
CVS _____	☐	☐
Neuro _____	☐	☐
GI _____	☐	☐
MSS _____	☐	☐
Psych _____	☐	☐

VITAL SIGNS

Weight _____
Height _____
BMI _____
BP _____
P _____
O2 _____

ADDITIONAL COMMENTS

_____

_____

PHYSICIAN SIGNATURE _____

Must be returned to Southgate Surgical Suites ***at least 7 days prior to appointment*** *or surgery will be cancelled*