Clinical Associates Ambulatory Surgery Center

515 Fairmount Avenue, Suite 100 Towson, MD 21286

Patient Medical & Surgical History

Directions: Please complete the following information. This form will be confidential and will provide us the information to give you quality care. Please bring this in the day of your procedure.

What **procedure** are you scheduled to have done?____

Why does your physician want to perform the procedure?_______________________________________

Name of adult transporting you home: ____

Contact Number of adult transporting you home: ____

Please answer Yes or No to the following disorders and provide an explanation as necessary

Disorder	Yes	No	Explanation
High Blood Pressure			
Heart Attack/Angina			
Congestive Heart Failure			
Heart Murmur/Mitral Valve Prolapse			
Valve Replacement			
Cardiac Surgery			
Irregular Heart Beat			
Internal Defibrillator/Pacemaker			
Asthma/Emphysema/COPD			
Lung Disease			
Diabetes			
Stomach Ulcer			
Liver Disease/Hepatitis/Other			
Infectious Disease/Other			
Kidney Disease/Other			
Bladder Problems			
Back/Neck Problems			
Any Joint Replacements			
Arthritis			
Seizures			
Stroke			
Glaucoma			
Thyroid Problems			
Cancer			
Any Past Surgeries?			
Other Medical Conditions			
Do you smoke? How much?			
Do you use recreational drugs? What kind? How much?			
Alcohol use?			
Allergies to medications/latex/contrast?			
Females: Is there any possibility you are pregnant?			

Patient Signature **Date** / **Reviewed by** **Date**