

# ENT Surgery Center of Atlanta LLC

5673 Peachtree Dunwoody Road, Suite 945 • Atlanta, GA 30342

PATIENT LABEL

Surgeon \_\_\_\_\_ Procedure \_\_\_\_\_

Instructions given \_\_\_\_\_ at \_\_\_\_\_ am/pm Instructions given to: \_\_\_\_\_ by \_\_\_\_\_

Date of Surgery \_\_\_\_\_ NPO food/milk \_\_\_\_\_ Clears \_\_\_\_\_ Patient Nickname: \_\_\_\_\_

Allergies: Medications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Foods: \_\_\_\_\_

Latex: \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Medical History

- Cardiac Problems/Hypertension  Yes  No
- Asthma/Bronchitis/Pneumonia/RAD/TB  Yes  No
- Snoring/Sleep Apnea/CPAP  Yes  No
- Blood Transfusion/Hepatitis/HIV  Yes  No
- Bleeding or Clotting Abnormalities  Yes  No
- Sickle Cell Disease/Trait  Yes  No
- Diabetes NIDD/Insulin  Yes  No
- Bowel or Colon Disease/GERD  Yes  No
- Kidney/Bladder/Prostate Disease  Yes  No
- Females: LMP \_\_\_\_\_

- Thyroid Disorder  Yes  No
- Seizure Disorder  Yes  No
- Arthritis/Spine/Joint Problems  Yes  No
- Recent Cold/Flu  Yes  No  
If yes, when \_\_\_\_\_
- Seasonal Allergies  Yes  No
- Tobacco Use:  Yes  No  
How much \_\_\_\_\_ How long \_\_\_\_\_
- Alcohol Use:  Yes  No  
How much \_\_\_\_\_ How often \_\_\_\_\_
- Glasses/Contacts/Cataracts/Glaucoma  Yes  No
- Dental: \_\_\_\_\_

EKG within last 6 months - 1 yr    
 If yes, where \_\_\_\_\_

Full term pregnancy  Yes  No  
If no, \_\_\_\_\_ weeks

Birthweight \_\_\_\_\_ lbs \_\_\_\_\_ oz.

Complications  Yes  No

Home with mother  Yes  No

Jaundice  Yes  No; Treated \_\_\_\_\_

Reflux  Yes  No; Resolved \_\_\_\_\_

Developmental Delays/ADD/ADHD  Yes  No

Breastfed / Bottle fed / Cup \_\_\_\_\_

Date of last immunizations \_\_\_\_\_

Height \_\_\_\_\_ Wt. \_\_\_\_\_

### Surgical History

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

	History		
	Anesthetic Complications		
	Yes	No	N/a
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History PONV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_