PATIENT REGISTRATION FORM

KING OF PRUSSIA SURGERY CENTER

PATIENT NAME:_____ **DOB:**	_____
Pharmacy Name: _____ **Telephone Number:** _____	
Do you need an interpreter? If so, what language? _____	Yes No
Could you be pregnant? **Last menstrual period?** _____	Yes No
Any physical disabilities requiring: Walker Wheelchair Cane Hearing Aid	Yes No
Do you have diabetes or trouble with your blood sugar? Insulin dependent? If yes, dosage? _____	Yes No
Are you on Dialysis? What is your schedule? _____	Yes No
Have you ever had a seizure? Explain: _____	Yes No
Have you ever had a stroke? **If yes, when?** _____ Explain: _____	Yes No
Are you prone to dizziness, fainting spells, or a weakness in your arms or legs? Date of last episode: _____	Yes No
Did you ever have a problem with anesthesia? Explain issue: _____ _____ _____	Yes No
Any implants? Defibrillator Pacemaker Stents Port/IV Access Metal Implants? If so body site: _____	Yes No

PATIENT NAME:_____ DOB:	_____
Any known blood disorders such as: Anemia Bleeding disorders DVT/Blood Clots Frequent nose bleeds Easy bruising Hepatitis Other: _____ Further explanation: _____	Yes No
Blood transfusions? Reason? _____ Date of most recent: _____	Yes No
Have you had a recent cough or cold, infections or fever? If yes, symptoms started: _____ If antibiotics taken type and dosage: _____	Yes No
Have you traveled outside of the US in the last 21 days? If yes, where? _____ When? _____	Yes No
Have you been diagnosed with acid reflux? If yes, explain: _____	Yes No
Do you snore?	Yes No
Have you been diagnosed with Sleep Apnea? Do you use CPAP?	Yes No Yes No
Any previous or existing heart condition? Explain: _____ _____	Yes No
Have you experienced any of the following? Chest Pain (Angina) High Blood Pressure Palpitations or irregular heartbeat Shortness of breath Further explanation: _____ _____ Cardiologist Name: _____ Cardiologist Phone Number: _____	Yes No
Have you ever had a surgical procedure before? If yes, type of Surgery? _____ Date of Surgery: _____	Yes No

PATIENT NAME:_____ DOB:	_____
Past or Present history of: Asthma Pneumonia Bronchitis Wheezing Tuberculosis Abnormal CXR Cancer treatment Other: _____ **Any additional pertinent medical history?** _____ _____ _____ _____ _____	Yes No

_____ _____

Patient Signature Date