OrthoIndy Center for Perioperative Care

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Your surgeon has referred you to our office to provide medical clearance for your upcoming procedure. You will meet with one of our nurse practitioners or physician assistants for a detailed medical history and brief physical exam, including an EKG and blood work (do not fast). Our goal is to provide you with the safest environment possible for your procedure and your recovery. **The visit to our office will be approximately 1 to 2 hours long.**

PLEASE BRING:

- **Insurance cards and a photo ID**
- A **current list of medications** (including dose and frequency). Remember to include insulin, inhalers, eye drops, vitamins, and herbal preparations.
- **IF APPLICABLE, any cardiac testing reports and/or other procedure notes** you have had done within the past five years (this includes: EKGs, stress tests, heart surgery, lung surgery, recent lab work, etc.). You may also have these faxed to our office by your physician.

We ask that you **ARRIVE 30 minutes prior to your appointment time** to allow for registration, vital signs, blood work, and an EKG to be done. **YOU MAY BE ASKED TO RESCHEDULE IF YOU ARE MORE THAN 15 MINUTES LATE FOR YOUR ARRIVAL TIME.** If you are required by your insurance policy to pay a copay, we will collect it at the time of registration.

If you have any questions, please call our office between the hours of 9am and 3pm. We look forward to treating you at our Perioperative Center!

Please complete all pages of this packet and BRING them to your appointment.

Patient Name:____ Date:______________

Please list all allergies and reactions.

ALLERGIES	REACTION

Please list all medications to include oral medications, inhaled medications, nasal sprays, inhalers, eye drops, vitamins, and herbal preparations. This list should be accurate as possible, since we will use it to manage your care at the time of surgery. If you have any questions about your medications, please bring the bottle or container at the time of your appointment.

MEDICATION LIST	DOSE	FREQUENCY
1.		**AM or PM**
2.		**AM or PM**
3.		**AM or PM**
4.		**AM or PM**
5.		**AM or PM**
6.		**AM or PM**
7.		**AM or PM**
8.		**AM or PM**
9.		**AM or PM**
10.		**AM or PM**
11.		**AM or PM**
12.		**AM or PM**

Reviewed by: ___________________________________ Date: __________

PIKE
medical consultants

Patient Name:____ Date:______________

Symptoms/Conditions Check (√) symptoms you currently have or have had in the past.

Constitutional	**Skin**	**Eyes**	**Ears/Nose/Throat/Mouth**
☐ Recent fever ☐ Weight gain ☐ Weight Loss	☐ Rashes ☐ History of MRSA or staph ☐ Open wounds ☐ Skin cancer	☐ Recent vision changes ☐ Glaucoma ☐ Cataracts ☐ Visual deficits ☐ Glass/contacts ☐ Macular degeneration	☐ Hoarseness ☐ Vertigo/dizziness ☐ Hearing loss ☐ Allergies/sinus problems ☐ Dentures/partials ☐ Hearing aids
Respiratory	**Cardiovascular**		**Hematologic**
☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Tobacco use in last 6 months ☐ Asthma ☐ Lung disease (COPD or emphysema) ☐ Sleep apnea ☐ Use CPAP/BIPAP	☐ Chest pain ☐ Palpitations ☐ Heart disease ☐ Heart attack ☐ Heart murmur ☐ High blood pressure ☐ High cholesterol or triglycerides ☐ Shortness of breath while lying flat	☐ Pacemaker/defibrillator ☐ Irregular heart rate or beat ☐ Atrial fibrillation ☐ Congestive heart failure ☐ Vascular/carotid disease (problem with blood flow)	☐ Easy bruising ☐ Anemia ☐ Bleeding disorder ☐ Blood clots (You or family members) – Location? _________________ ☐ Pulmonary embolism ☐ Blood transfusion ☐ Heavy menses
Stomach/Intestinal		**Urology**	**Endocrine**
☐ Heartburn/GERD ☐ Trouble swallowing ☐ Nausea/vomiting ☐ Abdominal pain ☐ Diarrhea ☐ Constipation	☐ Blood in stool ☐ Liver disease ☐ Ulcer ☐ IBS (irritable bowel syndrome) ☐ Diverticulitis	☐ Frequent urinary tract infections ☐ Incontinence ☐ Blood in urine ☐ Kidney stones ☐ Kidney disease ☐ Prostate enlargement ☐ Erectile dysfunction	☐ High blood sugars ☐ Diabetes ☐ Thyroid disease ☐ Hormone replacement
Musculoskeletal		**Neurology**	**Psych**
☐ Fractures in last 6 mos. ☐ Swelling ankles/feet/ hands ☐ Arthritis ☐ Rheumatoid arthritis ☐ Gout	☐ Joint pain ☐ Joint swelling ☐ Osteoporosis ☐ Back pain	☐ Stroke ☐ TIA (mini strokes) ☐ Seizures/epilepsy ☐ Headaches/migraines ☐ Numbness hands/feet ☐ Myasthenia gravis ☐ Parkinson's disease ☐ Dementia	☐ Depression ☐ Anxiety ☐ Insomnia ☐ Bipolar disorder ☐ Under the care of a psychiatrist ☐ Drug dependence ☐ Alcoholism
Other conditions			
☐ Organ transplant ☐ AIDS/HIV + status ☐ Cancer – type? _________________	☐ ____ ☐ ____ ☐ ____		

Reviewed by: __________________________________ Date: ___________

Patient Name:____ Date:______________

Surgeries / Hospitalizations / Serious Illness / Injuries

Mo/Year	Hospital	Reason/Outcome
_______	_______________	____
_______	_______________	____
_______	_______________	____
_______	_______________	____
_______	_______________	____
_______	_______________	____
_______	_______________	____
_______	_______________	____

Have you ever had a cardiac evaluation, stress test, or catheterization?

☐Yes ☐No If yes, Date:__________ Location:______________________

Family History

	Age / Age at death	Cause of death	Other health problems
Father	_________________	________________	________________________________
Mother	_________________	________________	________________________________
Siblings	_________________	________________	________________________________

Marital Status Check (√) your current status.

☐ Married ☐ Divorced ☐ Widowed ☐ Single

Occupation Check (√) your status

Are you currently employed? ☐ Yes ☐ No If yes, what do you do?__________________

Health Habits Check (√) which you currently use or have used in the past & describe.

		How much, How long?
	Tobacco	
	Alcohol	
	Street Drugs	
	Other	

Vaccination History Check (√) all that apply & write in the date you received the vaccine

	Influenza	
	Pneumonia	
	Other	

Reviewed by: ___________________________________ Date: ___________