UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

PATIENT SURGICAL ASSESSMENT

Please complete the assessment in the physician office and return to office staff.

Name:_____ DOB:_____/_____/_____ Daytime Phone:_____

Surgeon:_____ Family Physician:_____

Routine Daily Medication including appetite suppressants, over-the-counter (dosage & frequency), herbals, vitamins, & Home Oxygen.

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY
1.			10.		
2.			11.		
3.			12.		
4.			13.		
5.			14.		
6.			15.		
7.			16.		
8.			17.		
9.			18.		

HISTORY OF:	Y	N	HISTORY OF:	Y	N	HISTORY OF:	Y	N	HISTORY OF:	Y	N
STROKE			PNEUMONIA			TRANSFUSIONS			DIALYSIS		
TIA/SEIZURES			PACER/AICD			BLEEDING PROBLEMS			URINARY PROBLEMS		
MIGRAINES			HEART PROBLEMS			PHLEBITIS/BLOOD CLOTS			STONES		
HEADACHES			HEART ATTACK			CANCER			ARTHRITIS		
DEPRESSION			RASHED			LAUKEMIA			MRSA/VRE		
ANXIETY			BRUISE EASILY			CHEMO/RADIATION			DENTURES		
GLAUCOMA			PHYSICAL LIMITATIONS			DIABETES			GLASSES		
ASTHMA			LEARNING DISABILITIES			PREGNANT			CONTACTS		
SLEEP APNEA			HIATAL HERNIA/GERD			ALCOHOL ABUSE			HEARING LOSS - LEFT EAR		
COPD			ULCERS			TOBACCO			HEARING LOSS - RIGHT EAR		
BRONCHITIS			LIVER DISEASE			DRUG ABUSE			OTHER:		
EMPHYSEMA			HEPATITIS/LIVER DISEASE			THYROID PROBLEMS			OTHER:		
SINUS PROBLEMS			HIGH BLOOD PRESSURE			KIDNEY PROBLEMS			OTHER:		

List all Allergies including Drugs, Tape, Latex, Iodine, Soy Products, Food, and Environmental Allergy Reactions:

_____

Please list any major operations and approximate dates:

_____

Reaction to local or general anesthesia or blood relatives with problems: ❑ Yes ❑ No If yes, please explain:

_____

Where will you go to have the following test done?

LAB/EKG:_____ X-Rays:_____

Do you have an Advanced Directive? ❑ Yes ❑ No If Yes, please provide a copy on day of surgery.

Name of person providing transportation home upon discharge?

_____

Name of person staying with you the first 24 hours after surgery?

_____

Phone number where you can be reached after surgery:

_____

OFFICE STAFF: PEASE FAX THE SURGICAL ASSESSMENT FORM WITH YOUR POSTING FORM AFTER COMPLETION TO
UPPER CHESAPEAKE HEALTH SYSTEM POSTING OFFICE – 443-643-1615
NOT PART OF PERMANENT RECORD