

PATIENT SELECTION & HEALTH INFORMATION SHEET

OBGYN NAME _____ PRACTICE NAME & LOCATION: _____

DATE, TIME AND TYPE OF SCHEDULED SURGERY: _____

PARAGON AMBULATORY HEALTH RESOURCES 214-369-3030 FAX 214-987-0897

VERSION 7.6.10

NAME _____

Date & Time of surgery _____

Age _____ Birthdate _____

Preferred name _____

CELL# _____

EMERG CONTACT _____

Primary care physician _____

Date of last exam _____

Results of last exam _____

Date & Results of last lab work _____

Height _____ Weight _____

Insurance Company: _____

Could you be Pregnant? _____

alcoholic drinks per week _____

Recreational drug use _____

Problems w/ Anesthesia _____

Diet pill use _____

Recent Draining Sinuses _____

Caffeine per day _____

Any "colds" last 1 month _____

ALLERGIES	NO	YES	REACTION
LATEX			
IODINE			
CONTRAST DYE			
ANESTHESIA			
DRUGS:			
1			
2			
3			
4			

Do You Have a History Of:	YES	NO
Anemia		
Uterine Surgery		
Uterine Infections		
Pelvic Inflammatory Dz		
STD's		
Bleeding Disorder		
Clotting Disorder		
Coughing		
Seizures		
High Blood Pressure		
Partial Plates		
Dentures		
Asthma		
Shortness of Breath		
Smoking		
Recent URI *		
Acid Reflux/Heartburn		
Ulcers		
Hiatal Hernia		
Arthritis		
Joint Pain		
Depression		
Anxiety		
Panic Attacks		
Chemical Dependency Hx		
AA Member		
Cancer		
Dizziness/Fainting		
Numbness/Tingling		
Implants		
Prosthesis		
Sickle Cell Disease		
Hepatitis		
AIDS		
Lupus		
Autoimmune Disease		
Blood in Urine		
Kidney Stones		
Thyroid Problems		
Pituitary Problems		
Headaches/Migraines		
Vision Problems		
Glaucoma		
Recent Contagious Illness		
Contagious Illness Exposure		
Irregular Heartbeat		
Rapid Heartbeat		
Abdominal Pain		
Nausea/Vomiting		
Diarrhea/Constipation		
Diabetes		
Skin problems/Bruising		
Muscle spasms/Weakness		
Fatigue/Low Energy		

Meds, herbs, diet meds, inhalers, vitamins, patches:

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

Personal Preferences:
Music _____

---END OF PATIENT PORTION---

NOTE:
PLEASE FAX THIS COMPLETED FORM TO PARAGON AT LEAST THE DAY BEFORE SURGERY. 214.987.0897

ABNORMAL LAB RESULTS:

H/H if pt has a hx of recent symptomatic anemia.

BMI: _____

BODY MASS INDEX
BMI=KG/M²

HEIGHT/OBESITY³/MORBID⁴

	30	35
4'10"	65	76
4'11"	68	79
5'0"	70	81
5'1"	72	84
5'2"	75	87
5'3"	77	90
5'4"	80	93
5'5"	82	96
5'6"	85	99
5'7"	87	102
5'8"	90	105
5'9"	92	108
5'10"	95	111
5'11"	98	114
6'0"	101	118
6'1"	104	120
6'2"	106	124
6'3"	109	127

Plano Women's Healthcare, P.A.

OBSTETRICS, GYNECOLOGY & INFERTILITY

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FASTING GUIDELINES FOR OFFICE SURGERY 6.7.09

UNTIL TWO HOURS

BEFORE YOUR SCHEDULED SURGERY START TIME YOU MAY HAVE THE FOLLOWING LIQUIDS:

Coffee

(SUGAR, SWEETENER, NON-DAIRY CREAMER OK)

Tea

(SUGAR, SWEETENER, NON-DAIRY CREAMER OK)

Soft Drinks:

(COKE, SPRITE, GINGER ALE, ETC)

Water

Fruit Juices **WITHOUT** Pulp

(Such as apple, cranberry or grape)

Plain Jell-O

(No fruit, No dairy)

Clear Chicken Broth

(Swanson's Canned is ok)

Do not drink MILK or DAIRY Products

Do not drink juice with pulp

(Most orange juice has pulp)

UNTIL SIX HOURS

BEFORE YOUR AFTERNOON SURGERY START TIME YOU MAY FOLLOW THE ABOVE DIRECTIONS FOR LIQUIDS

PLUS....A light breakfast of one or two pieces of dry toast with jam or jelly only and one poached or boiled egg (no oil)

OR: 2 pancakes with syrup only (no butter)

UNTIL EIGHT HOURS

BEFORE YOUR SURGERY

You may have a normal breakfast followed by all of the above liquids (Until two hours before surgery)

Women Providing Health Care for Women