

DATE OF	PHYSICIAN PERFORMING
PROCEDURE	PROCEDURE
	MEDICAL RECORD #
	(FOR WSC LISE)

## PRE-PROCEDURE HEALTH HISTORY LASER PATIENTS

NAN	ИЕ:						
LAST			FIRST			M.I.	
DAT	E OF BIRTH:	SEX	:	PHONE #: _(	)		
	ARE YOU <b>ALLERGIC</b> TO IF YES, LIST WITH TYPE		_	NO		SHT L	
	LIST ALL MEDICATIONS SUPPLEMENTS AND OV NAME OF MEDICATION	ER THE COUNTER M	EDICATIONS.		CESSARY)		
	(b) HEART PROBLEMS, II  (c) PACEMAKER	ING PROBLEMS			YESYESYES	NO NO NO NO NO NO	
	(h) HEPATITIS(i) ANY SERIOUS INFEC	TIONS			YES	NO NO	
	(j) OTHER MEDICAL PRO					NO	
	DO YOU HAVE AN ADVANG IF YES, WHICH?	,	•		ING WILL? YES	S NO	
١	WESTFALL SURGERY CENTER H	HAS PACKETS OF INFORMA	TION ON ADVANCE	DIRECTIVES READILY AV	AILABLE FOR ALL PAT	IENTS.	
	DATE		PATIE	NT SIGNATURE			
PAT	TIENT HISTORY FORM	REVIEWED BY:			DATE:		

## LASER PATIENTS

PLEASE FILL OUT THIS FORM AND BRING IT WITH YOU ON THE DAY OF YOUR LASER PROCEDURE. YOUR PROCEDURE WILL BE PERFORMED ON THE 1<sup>ST</sup> FLOOR OF WESTFALL SURGERY CENTER. PLEASE ARRIVE AT YOUR SCHEDULED TIME AND PLAN ON BEING AT WESTFALL FOR APPROXIMATELY 1½-2 HOURS.