



710 Oak Commons Boulevard, Kissimmee, Florida, 34741 (407-846-6747)  
2900 17<sup>th</sup> Street, #4, St. Cloud, Florida, 34769  
3100 17<sup>th</sup> Street, St. Cloud, Florida, 34769  
1018 Cypress Parkway, Kissimmee, Florida, 34759

**ATTENTION PATIENTS WITH SCHEDULED PROCEDURES!!!**

**PLEASE BE ADVISED:** When scheduling a procedure (colonoscopy and/or endoscopy) **FOUR** different possible fees take place.

**MRN #:** \_\_\_\_\_

**PROFESSIONAL (Doctors) FEE:**

You will be contacted prior to the procedure date to inform you of the upfront professional fee due on the morning of the procedure. This is for the doctor's service. Please be advised, if you have a Medicare plan your insurance will be billed first and if there is a remaining balance a statement will be sent to you. If you have any questions regarding the Professional Fee, contact us at 407-846-6747, extension 223.

**Please initial:** \_\_\_\_\_

**FACILITY FEE:**

You will be contacted by Kissimmee Endoscopy Center prior to the procedure date to inform you of your upfront facility fee due on the morning of the procedure. This is for the materials and the room being used for the procedure. If you have any questions regarding the facility fee, contact Kissimmee Endoscopy Center at 407-931-2816, extension 138.

**Please initial:** \_\_\_\_\_

**ANESTHESIA FEE:**

The anesthesiologist will be billing all medical insurances first for his service and the anesthesia. If there is a remaining balance due after your insurance has paid, a statement will be sent to you. If you have any questions regarding your anesthesia benefits, please contact your insurance plan.

**Please initial:** \_\_\_\_\_

**PATHOLOGY FEE: (if applicable)**

If a biopsy is taken at the time of the procedure, the lab will bill your insurance for the handling and reading of the specimen. If there is a remaining balance after your insurance has paid, a statement will be sent to you. If you have any questions regarding your pathology benefits, please contact your insurance plan.

**Please initial:** \_\_\_\_\_

***\*Gastroenterology Associates of Osceola, P.A. only collects an estimated fee. We do not know the exact amount until your insurance plan processes the claim.***

I have read and understand the possible fees above and I am aware that I am responsible for any balance not paid by my insurance.

\_\_\_\_\_  
Patient Signature / Date of Birth

\_\_\_\_\_  
Date Signed

*Thank you for trusting us with your gastro healthcare!*



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**ATENCIÓN PACIENTES QUE TIENEN CITAS PARA PROCEDIMIENTO!!!**

**POR FAVOR, TENER ASESORAMIENTO:** Cuando programe un procedimiento (colonoscopia y/o endoscopia) **CUATRO** posibles diferentes cargos tendrán lugar. **MRN #:** \_\_\_\_\_

**CARGOS PROFESIONALES (DOCTOR):**

Usted será contactado antes de la fecha de su procedimiento para informarle del el cargo profesional, que tiene que pagar por adelantado en la mañana de su procedimiento. Esto es para el servicio del medico, asegurese si usted tiene un plan de Medicare su seguro será facturado primero y si hay saldo restante una factura será enviada a usted. Si usted tiene alguna pregunta con respecto a la tarifa profesional nos puede contactar al 407-846-6747, extensión 223. **Por Favor sus Iniciales:** \_\_\_\_\_

**CARGOS DE FACILIDAD:**

Usted será contactado por Kissimmee Endoscopy Center antes de la fecha de su procedimiento para informarle de los cargos de facilidad, que tiene que pagar por adelantado en la mañana de su procedimiento. Esto es para los materiales y la habitación que se utilizara para su procedimiento. Si usted tiene alguna pregunta con respecto a la tarifa de facilidad puede contactar a Kissimmee Endoscopy Center at 407-931-2816, extensión 138. **Por Favor sus Iniciales:** \_\_\_\_\_

**CARGOS DE ANESTESIA:**

El anestesiólogo facturara todos los seguros medicos primero por su servicio, por la anestesia. Si hay cargos restante será enviado al paciente. Si usted tiene alguna pregunta con respecto a los beneficios de la anestesia, por favor contacte su seguro medico. **Por Favor sus Iniciales:** \_\_\_\_\_

**CARGOS DE PATOLOGIA: (si aplica)**

Si le toman biopsia en el momento de su procedimiento, el laboratorio facturara a su seguro por la obra y lectura de la muestra. Si usted tiene alguna pregunta con respecto a los beneficios del laboratorio, por favor contactar su seguro medico. **Por Favor sus Iniciales:** \_\_\_\_\_

***\*Gastroenterology Associates of Osceola, P.A. solo colecta estimados de cargos. No sabemos la cantidad exacta hasta que su compania procese los reclamos!***

He leído y entendido los posibles cargos nombrado en esta carta y estoy consiente de lo que mi seguro no cubre, voy hacer responsable.

\_\_\_\_\_  
Firma del Paciente/Fecha de Nacimiento

\_\_\_\_\_  
Date Signed

*Gracias por confiar en nosotros con su salud Gastrointestinal!*

**The Kissimmee FL Endoscopy ASC, LLC**  
715 Oak Commons Blvd, Kissimmee, FL 34741  
407-931-2816 Phone      407-931-3485 Fax

***PLEASE COMPLETELY FILL OUT THE ATTACHED AND BRING THEM WITH YOU TO THE KISSIMMEE FL ENDOSCOPY ASC, LLC ON THE DAY OF YOUR SCHEDULED PROCEDURE.  
THANK YOU***

Instructions for patients having outpatient procedures at The Kissimmee FL Endoscopy ASC, LLC:

The Kissimmee FL Endoscopy ASC, LLC is located at 715 Oak Commons Blvd, across the street from the Doctor's Office. Normal business operations for this building are Monday thru Friday, closed Saturdays and Sundays.

Our goal is to make your visit to our facility a smooth, convenient, and time efficient process, so the facility finds it necessary to inform patients of special building conditions.

1. The surgery scheduler at the doctor's office will give the patient paperwork to be completed ***prior*** to arrival for their procedure at the surgery center. Please remember to bring the forms completed and signed.
2. Building entrances open at 0700 AM.
3. There is a restroom located in the lobby for your convenience.
4. Patients having a procedure are ***not allowed to eat or drink*** as instructed in their instructions.
5. Please be advised that you may be at The Kissimmee FL Endoscopy ASC, LLC for at least 2-3 hours. The waiting area can be cold at times, so please bring a sweater or jacket for your comfort.
6. Due to limited seating, we kindly request that each patient be accompanied by only one person, a responsible adult, ***who will remain on premises during the patient's entire visit.***
7. Smoking is prohibited.
8. After the procedure patients will be escorted out through the Exit closest to the parking lot.

**The Kissimmee FL Endoscopy ASC, LLC**  
715 Oak Commons Blvd, Kissimmee, FL 34741  
407-931-2816 Phone 407-931-3485 Fax

*Favor de completar y traer con usted al Kissimmee FL Endoscopy ACS, LLC el dia de su procedimiento.  
Gracias.*

Instruccions para pacientes que van a tener procedimiento en el Kissimmee FL Endoscopy ASC, LLC:

El Kissimmee FL Endoscopy ASC, LLC esta localizado en el 715 Oak Commons Blvd (al frente de la oficina de los doctores.) Los dias laborables son de Lunes a Viernes, cerrado Sabados Y Domingos.

Nuestra meta es que al visitar nuestra facilidad usted tenga un servicio agradable, conveniente y eficiente, y que se le brinde toda la informacion necesaria.

1. La cita se le hara en la oficina del medico y alli se le entregara todos los papeles, que deben ser completados y firmados y traer los el dia de su estudio.
2. El Centro de Endoscopia habre a las 7:00 am
3. El bano esta localizado en el lobby.
4. Los pacientes que tienen procedimientos **no pueden comer ni beber** nada segun las instrucciones dadas.
5. Favor de tener presente que el paciente permanecera en el Kissimmee FL Endoscopy ASC, LLC al menos de 2-3 horas. Favor de traer un abrigo, ya que el area de espera siempre esta frio.
6. Debido al espacio limitado se le pide a cada paciente que venga acompañado de una sola persona adulta, que **debera permanecer en la clinica en todo momento hasta que el paciente le permitan irse a su casa.**
7. FUMAR ESTA PROHIBIDO.
8. Despues del procedimiento el paciente sera escortado por la puerta de salida mas cerca al estacionamiento.

## HOME MEDICATION LIST - (Lista de Medicamentos)

Please fill form out as completely as possible.  
(Favor completar este formulario.)

Medication Name (Nombre del Medicamento)	Dosage (Dosis)	Route (Indicacion)	Frequency (Frecuencia)	Last Date Taken (Ultima vez que la tomo)	Medication taken for what reason (Razon porque toma este medicamento)
<b>Allergies</b> (Alergias)	<b>Reaction to medication</b> (Reaccion algun medicamento)				

# Patient Rights and Notification of Physician Ownership

Label for Medical Records

Amsurg Corporation  
The Kissimmee FL Endoscopy ASC, LLC  
715 Oak Commons Blvd.  
Kissimmee, FL 34741  
407-931-2816  
Fax: 407-931-3485

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISION REGARDING HIS/HER CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE PRIOR TO THE PROCEDURE/SURGERY.

## **Patient's Rights:**

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

## **Patient Responsibilities:**

- The patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- The patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- The patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions should he or she refuse treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

## **If you need an interpreter:**

If you need an interpreter, **please let us know** and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

## **Rights and Respect for Property and Person:**

### ***The patient has the right to:***

- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice a grievance regarding treatment or care that is, or fails to be furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Confidentiality of personal medical information.

**Privacy and Safety**

***The patient has the right to:***

- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.

**Advance Directives:**

***You have the right to information regarding advance directives, this facility's policy on advance directives, and information regarding state regulations concerning advance directives. Applicable state forms are available from the center and will be provided upon request.***

When a person becomes unable to make decisions due to a physical or mental change or condition, they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death. The state rules that address this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code and Florida statute Title XLIV, Chapter 765.

Kissimmee Endoscopy Center respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

<http://www.floridahealthfinder.gov/reports-guides/advance-directives.shtml>  
1-888-419-3465

**Complaints/Grievances:**

If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.

The following are the names and/or agencies you may contact:

Charmaine Ephriam  
Center Director  
715 Oak Commons Blvd., Kissimmee, FL 34741  
407-931-2816

You may contact the state to report a complaint:

Florida Department of Health  
Consumer Services Unit  
4052 Bald Cypress Way, Bin C-75, Tallahassee, Florida 32399-3275  
Phone (850) 245-4339 or TF 1-888-419-3456  
[http://www.doh.state.fl.us/mqa/enforcement/enforce\\_home.html](http://www.doh.state.fl.us/mqa/enforcement/enforce_home.html)

Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman at [www.medicare.gov/Ombudsman/resources.asp](http://www.medicare.gov/Ombudsman/resources.asp)

**Medicare:** [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE (1-800-633-4227)

**Office of the Inspector General:** <http://oig.hhs.gov>

This facility is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Complaints or grievances may also be filed through:

AAAHC  
5250 Old Orchard Road, Suite 200, Skokie, IL 60077  
847-853-6060 or email: [info@aaahc.org](mailto:info@aaahc.org)

**Physician Financial Interest and Ownership:**

The center is owned, in part, by the physicians. The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations.

**The following physicians have a financial interest in this center**

- M. Siraj UI Islam, MD
- Syed Khalid Lateef, MD FACG
- Jaime M. River, MD

X \_\_\_\_\_  
Signature of Patient or Patient Legal Representative

**PLEASE BRING THIS FORM WITH YOU  
ON THE DAY OF YOUR PROCEDURE**

Date \_\_\_\_\_

# The Kissimmee FL Endoscopy ASC, LLC

715 Oak Commons Blvd., Kissimmee, FL 34741

407-931-2816 Phone 407-931-3485 Fax

## ANESTHESIA QUESTIONNAIRE - ADULTS

*Please answer each question prior to your procedure. This will assist the Anesthesia Department in making your pre-anesthesia evaluation.*

1. Please list any major illnesses you have had in your life. \_\_\_\_\_  
\_\_\_\_\_
2. Please list any medication that you take and their doses. \_\_\_\_\_  
\_\_\_\_\_

<b>CHECK YES OR NO</b>	<b>YES</b>	<b>NO</b>
3. Have you taken prednisone, steroids, or ACTH in the past six months? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you allergic to any medications: If yes, what? _____ What happens? _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had high or low blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had trouble with your heart? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a heart attack? If yes, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have angina chest pains? If yes, how often? _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have any trouble with your breathing or lungs? .....	<input type="checkbox"/>	<input type="checkbox"/>
(circle) Asthma Wheezing Emphysema Cough up anything		
10. Do you smoke? If yes, how much? _____	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had a cold or flu in the past two weeks? .....	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in the family have a cold or flu? .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have any problems with your breathing while lying flat? .....	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had a stroke? If yes, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever had dizziness, fainting spells, seizures, or epilepsy? .....	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have any part of your body that is numb or weak? .....	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had any problems with your liver or kidneys? .....	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had hepatitis or yellow jaundice? If yes, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have problems with swallowing, heartburn, indigestion, hiatal hernia, or vomiting? .....	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you have diabetes? If yes, how long? _____	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you have arthritis? If yes, where? _____	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever had problems with bleeding or easy bruising? .....	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had a transfusion? If yes, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you wear contact lenses? If yes, please remove before surgery. ....	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have (circle) dentures caps bridges loose teeth?	<input type="checkbox"/>	<input type="checkbox"/>
26. Please list any operations you have had and their dates _____ _____		
27. Have you ever had any problems with general anesthetic? If yes, what? _____	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you ever had any problems with spinal anesthetic? .....	<input type="checkbox"/>	<input type="checkbox"/>
29. Have any relatives had any problems with anesthetics (high fevers, breathing troubles, etc.)? .....	<input type="checkbox"/>	<input type="checkbox"/>
30. How many drinks or beers do you have in an average day? _____ Week? _____	<input type="checkbox"/>	<input type="checkbox"/>
31. Is there any chance you are pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>
32. Date of your last menstrual period _____		
33. Height _____ Weight _____		
34. Do you have any questions? .....	<input type="checkbox"/>	<input type="checkbox"/>

Patient signature   X   \_\_\_\_\_ Date \_\_\_\_\_



## CUESTIONARIO PARA ANESTESIA – ADULTOS (ANESTHESIA QUESTIONNAIRE – ADULTS)

Por favor responda a cada pregunta antes de su operación. Esto ayudará al Departamento de Anestesia a realizar su evaluación pre-anestesia.

1. Por favor mencione todas las enfermedades serias que haya tenido en su vida. \_\_\_\_\_  
\_\_\_\_\_
2. Mencione los medicamentos que toma y sus dosis. \_\_\_\_\_  
\_\_\_\_\_

### CHEQUEE SI O NO

- |  | SI                       | NO                       |
|--|--------------------------|--------------------------|
| 3. Ha tornado prednisona, esteroides, o ACTH en los últimos seis meses? .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Es alérgico(a) a alguna medicina? _____ A cuál? _____ Cómo reacciona a la(s) misma(s)? _____            | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Ha tenido alguna vez la presión arterial alta o baja? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ha tenido problemás cardiacos? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ha sufrido un ataque al corazón alguna vez? _____ Cuando? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Padece de dolores anginosos? _____ Cuán frecuentes? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Padece de problemas respiratorios o pulmonares? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (circule el área) Asma Ruido al respirar Enfisema Tos con esputos  |                          |                          |
| 10. Fuma? _____ Cuántos cigarrillos/paquetes? _____ Por cuánto tiempo? _____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ha tenido usted catarro o el flú en las últimas dos semanas? .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Hay alguien en su familia con catarro o el flú? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Tiene usted problemas al respirar cuando esta, acostado(a) sobre su espalda? .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ha sufrido una embolia alguna vez? _____ Cuando? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ha tenido alguna vez (circule el área) mareos, desmayos, convulsiones, ataques epilépticos? .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Hay alguna parte de su cuerpo que esté insensible o débil? .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Ha tenido alguna vez problemas con su hígado o riñones? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Ha tenido alguna vez hepatitis, ictericia? _____ Cuando? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Tiene usted problemas al tragar, (circule el área) acidez, indigestion, hernia hialal o vómitos? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Padece de diabetes? _____ Desde cuándo? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Padece de artritis? _____ Donde? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Ha tenido alguna vez problemas de sangramiento o facilidad para magulladuras? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Ha recibido alguna vez una transfusión de sangre? _____ Cuando? _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Usa usted lentes de contacto? Si es así, por favor quíteselos antes de la operación.....               | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Tiene usted (circule de área) dentadura postiza coronas puentes dientes flojos                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Por favor detalle todas las operaciones a las que se ha sometido y sus fechas _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Ha tenido problemas alguna vez con anestesia general? _____ Que tipo de problemas? _____               | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Ha tenido problemas con anestesia requídea? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Ha tenido algún familiar problemas con anestesia (fiebre alta, problemas respiratorios, etc.)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Cuántos tragos o cervezas toma usted por día? _____ por semana? _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Hay alguna posibilidad de que usted esté embarazada? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Fecha de su última menstruación? _____   |                          |                          |
| 33. Estatura _____ Peso _____  |                          |                          |
| 34. Tiene usted alguna otra pregunta? .....  | <input type="checkbox"/> | <input type="checkbox"/> |