

Mid Valley Dermatology & Cosmetic Surgery Center

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(818) 907-SKIN (7546)

PRE-OPERATIVE QUESTIONNAIRE

AGE _____ WT _____ HT _____

BP _____ PULSE _____ TEMP _____

Check one:
YES NO

1. Do you wear contact lenses?
2. Do you have dentures, caps or loose teeth?
3. Do you wear a hearing aide?
4. Do you wear a prosthetic device such as a glass eye or an artificial limb?
5. Do you have a pacemaker?
6. Have you had any heart valves replaced?
7. Have you had any joints replaced?
8. Do you have difficulty moving your joints, arms, legs or back?
9. Do you drink alcohol? How much? _____
10. Do you smoke? How much? _____
11. Have you ever had a bad reaction or allergy to a medication or drug?
Explain: _____

12. Have you ever taken cortisone or steroid preparation within the past two years?
Drug _____ How much? _____ When? _____
13. Have you ever had a serious illness?
Explain: _____

14. Have you ever had any of the following:

<input type="checkbox"/> shortness of breath	<input type="checkbox"/> wheeze (asthma)	<input type="checkbox"/> heart attack
<input type="checkbox"/> cough or bronchitis	<input type="checkbox"/> ankle swelling	<input type="checkbox"/> numbness
<input type="checkbox"/> chest pain	<input type="checkbox"/> heart murmur	<input type="checkbox"/> seizure problem
<input type="checkbox"/> irregular or extra heartbeat	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> diabetes ("sugar")
<input type="checkbox"/> hepatitis or jaundice	<input type="checkbox"/> easy bruising or bleeding	<input type="checkbox"/> kidney problem
<input type="checkbox"/> joint stiffness	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> other health problem(s)
15. Are you presently being treated for any medical problems? Explain: _____

16. Do you take any medicines or drugs (example: aspirin, blood thinners, water pills, eye drops, etc.)
Name of drug _____ How much _____

17. Had you ever had an operation?
If YES please list the type and year starting with the most recent.

18. Have you ever had a blood transfusion?
19. Have you, or any family member, had a reaction or death related to a local or general anesthesia?

FOR WOMEN ONLY

20. Is there any possibility that you might be pregnant?
21. If you are having surgery on your reproductive organs, when was your last menstrual period? _____

PATIENT SIGNATURE _____ DATE _____

Mid Valley Dermatology & Cosmetic Surgery Center
Allan S. Wirtzer, MD, Medical Director
What You Should Know about Our Facility & Your Patient Rights

IN ACCORDANCE WITH HEALTH AND SAFETY CODES, THE ASC AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST
OF PATIENT RIGHTS:

Our Surgery Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment, or the source of payment for his or her care.

1. Considerate and respectful care.
2. Knowledge of the name of the physician who has primary responsibility for coordinating his or her care and the names of the professional relationships of other physicians who will see the patient.
3. Receives information from his or her physician about his or her illness, his or her course of treatment and his or her prospects for recovery in easily understood terminology.
4. Receives as much information about any proposed treatment or procedure as he or she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved and knowledge of the person who will carry out the procedure or treatment.
5. Participates actively in decisions regarding his or her medical care, to the extent permitted by law, including the right to refuse treatment.
6. Receives full consideration of privacy concerning his or her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to know the reason for the presence of any individual.
7. Is given confidential treatment of all communications and records pertaining to his or her care and his or her stay in the ASC. His or her written permission shall be obtained before his or her medical records can be made available to anyone not directly concerned with his or her care.
8. Receives reasonable responses to reasonable requests he or she may make for services.
9. He or she may leave the ASC, even against the advice of his or her physicians.
10. Receives reasonable continuity of care and advance knowledge of the time and location of appointment, as well as knowledge of the physician providing the care.
11. Is advised if ASC/personal physician proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in any research projects.
12. Will be informed by his or her physician, or a delegate of his or her physician, of his or her continuing health care requirements following his or her discharge from the Surgery Center.
13. May choose a different physician than was assigned to that patient.
14. Is made aware that this facility does not honor Advanced Directives.

For complaints, comments or concerns about your medical care, you may contact our Administrator or Medical Director/Owner Allan S. Wirtzer, M.D. at (818)907-7546 or you may contact the **CDPH, California Department of Public Health, Division of Health Facilities, 5555 Ferguson Drive, Suite 320, Commerce, CA 90022**; or you may contact the Office of the Medicare Beneficiary Ombudsman at: www.cms.hhs.gov/center/ombudsman.asp.

PATIENT RESPONSIBILITIES

As a patient in our facility, you have certain responsibilities, which include:

- ◆ To work with your health care team and to follow all safety rules.
- ◆ To show respect and consideration to our staff and to other patients and visitors.
- ◆ To respect the privacy of other patients.
- ◆ To give your health care team complete and correct information about your health.
- ◆ To tell your doctor about any changes in your health after you leave the facility.
- ◆ To keep, or cancel in a timely manner, your scheduled appointments for your health care.
- ◆ To follow the directions given by your team after you have agreed to treatment in our facility.
- ◆ To tell your health care team if you wish to change any of your decisions.
- ◆ This facility does not honor Advanced Directives.
- ◆ To ask for clarification if you do not understand any information or instructions given to you by your health care team.

IF YOU HAVE CONCERNS:

If you have any questions or concerns about your responsibilities, you can contact our administrator or Medical Director/owner Allan S. Wirtzer, M.D.

If you then wish to file a complaint about your care in our facility you may contact the following agency: CDPH, California Department of Public Health, Division of Health Facilities, 5555 Ferguson Drive, Suite 320, Commerce, CA 90022; or Accreditation Association for Ambulatory Health Care, 5260 Old Orchard Road, Suite 200, Skokie, IL 60077

You may also contact the Office of the Medicare Beneficiary Ombudsman at the following website: www.cms.hhs.gov/center/ombudsman.asp.

I have received, read and understand the
Information provided to me.

Date: