Ambulatory Surgery Center of Western New York
3112 Sheridan Dr.
Amherst, NY 14226

Self Reporting History and Physical

PATIENT NAME______________________SIGNATURE____________________
PATIENT ADDRESS____
RACE : ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Native American

PATIENT PHONE#____

PROCEDURE____
DATE OF SURGERY____

PRIMARY CARE PHYSICIAN NAME____________________________

Allergies: List all drug allergies

Drug	**Reaction**
1.__________	________________
2.__________	________________
3.__________	________________
4.__________	________________

Other types of allergies:

Food or Material	**Reaction**
1.______________	___________________
2.______________	___________________
3.______________	___________________
4.______________	___________________

CURRENT MEDICATIONS/OVER THE COUNTER VITAMINS & DOSAGES

MEDICATIONS	DOSAGES	MEDICATIONS	DOSAGES
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

LIST ANY MAJOR MEDICAL PROBLEMS

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☐ History Reviewed and approved for surgery

MD Signature:__________________________