

Patient Sticker on Arrival

PRE OPERATIVE QUESTIONNAIRE page 1

Name: _____ Date of Surgery: ____ / ____ / ____
Last First Middle Initial
 Age: _____ Date of Birth: ____ / ____ / ____ Height: ____ ft ____ in Weight: _____ lbs
 Surgeon: _____ Primary M.D. _____

MEDICATIONS - please read from medication bottles <input type="checkbox"/> NONE Include "blood thinning" meds, aspirin, and over-the counter, weight loss, and/or herbal supplements					
Medication Name	Dosage	Times/day	Medication Name	Dosage	Times/day

RECENT SURGERIES/MAJOR HOSPITALIZATIONS	
Procedure	Year

ALLERGIES <input type="checkbox"/> NONE	
Medication / Allergen	Reaction

In Case of an Emergency, Please Notify...	
Name	
Relationship	
Telephone	
Who is driving you home from the surgery center?	
Name	
Telephone	

Anesthesia Questions	YES	NO
Have you or any one in your family ever had a reaction or complication from a general or local anesthetic?		
History of post op nausea ?		
Other		

Please note anything (health or otherwise) that might help us take better care of you.

If more space is needed, please use other side.

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GENERAL HEALTH

Do you have, or have you ever had any of the following?

Nervous System	YES	NO
Seizures &/or Epilepsy		
Strokes		
Paralysis or weakness		
Equilibrium problems		
Migraine Headaches		
Other Neurological problems		
Alzheimer's or dementia		
Heart & Blood Vessels	YES	NO
High blood pressure		
Heart Attack : year _____		
Chest Pain: last episode _____		
Irregular Heart Beats		
Heart Failure		
Heart Murmur/ mitral valve prolapse		
Pacemaker (bring implant card)		
Automatic Internal defibrillator (bring card)		
Bleeding Problems		
Anemia (recent)		
Personal	YES	NO
Do you drink Alcohol		
# glasses/day _____ #glasses/wk _____		
History of recreational drug use		
Anything removable in your mouth		
Do you wear glasses/contacts		
Women: Are you/could you be pregnant		
Last Menstrual Period _____		
Body Piercings remove all metal jewelry before surgery		
Hard of hearing (circle) right left		
Hearing Aid (circle) right left		
PATIENTS UNDER 12	YES	NO
Premature birth or birth defect		
Genetic disorders		
Recent upper respiratory infection		

Respiratory System	YES	NO
History of smoking		
Sleep Apnea/Snoring		
Pneumonia or bronchitis		
Asthma or wheezing		
Shortness of Breath		
Emphysema / COPD		
Tuberculosis		
Other Lung Problems / home oxygen		
Gastro-Intestinal / Urinary / Abdomen	YES	NO
Kidney disease		
Ulcers		
Hiatal Hernia		
Hepatitis / Jaundice		
Gastric Reflux Disease / "Heart Burn"		
Special bowel/bladder needs		
Diabetes: <input type="checkbox"/> insulin dependent, <input type="checkbox"/> diet controlled, <input type="checkbox"/> oral medication		
Average Morning Blood Sugar _____		
Benign Prostatic Hypertrophy		
Other abdominal problems		
Skeletal / Other	YES	NO
Osteoporosis / Arthritis		
History of Back or Neck Surgery		
Chronic Pain		
Fibromyalgia		
Immune Deficiency		
Recent Cough, Cold, Flu, infections		
Skin infections: spider bite, boils <input type="checkbox"/> current, <input type="checkbox"/> previous		
History of antibiotic resistant infections		
Current outbreak of herpes		
History of cancer (location)		
Latex: Sensitivity or Allergy		

If more space is needed, please use other side.

Signature of person completing questionnaire _____

Relationship _____