# PREOP HEALTH PATIENT QUESTIONNAIRE

***Please complete this questionnaire and return to the nurse or receptionist.***

**Patient Name:** ______________________ **Date:** ____________

**Please list all physicians who are currently treating you:**

| MD Name | MD Specialty |
|---|---|
| | |
| | |
| | |
| | |
| | |

Age: ____ Height: _____ Weight: ____ lbs Occupation: ____________

Do You Smoke? no ____ yes ____ How many packs per day? ______

Do you consume alcohol? no ____ yes ____ How many drinks per day? ______

Do you use recreational drugs? no ____ yes ____ Use per day? ________

Do you use Herbal Supplements? no ____ yes ____ If yes, list ________________________

Any possibility you are pregnant? no ____ yes ____ Last Menstrual Period ________

Have you or any family members had Malignant Hyperthermia or any other problems with anesthesia?

no ____ yes ____ Please explain________________________________

| Previous Surgery | Date | Type of Anesthestic | Unusual Reactions |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Have you ever suffered from the following conditions?**

***Please circle condition if YES***

| | | |
|---|---|---|
| no | yes, when __________ | severe anxiety, depression, nervous breakdown, other mental illness |
| no | yes, when __________ | stroke, TIA, paralysis, narcolepsy, convulsions, epilepsy or migraine headaches |
| no | yes, when __________ | Pinched nerves, whiplash, chronic neck or back pain, arthritis, or bone disease |
| no | yes, when __________ | Ataxia (imbalance), vertigo, hearing loss |
| no | yes, when __________ | Nasal obstruction, bleeding, polyps |
| no | yes, when __________ | Jaw pain, hard to chew or open mouth |
| no | yes, when __________ | Hoarseness, difficulty swallowing |
| no | yes, when __________ | Skin disorders, skin cancers, psoriasis, rash, bruises, discolored lumps or masses |
| no | yes, when __________ | Asthma, chronic bronchitis, emphysema, collapsed lung, blood clots, pneumonia, chronic cough, sleep apnea, use CPAP or oxygen, TB |
| no | yes, when __________ | High blood pressure, chest pain, shortness of breath at night or upon lying down, abnormal EKG, irregular heartbeat |
| no | yes, when __________ | Heart attack, heart surgery, stent or angioplasty, heart failure, pacemaker implanted defibrillator, atrial fibrillation, heart murmur, Mitral Valve Prolapse |
| no | yes, when __________ | Heartburn, hiatal hernia, peptic ulcers reflux, GERD |

***PLEASE CONTINUE ON THE REVERSE SIDE***

**Have you ever suffered from the following conditions?**

*Please circle condition if YES*

| | | |
|---|---|---|
| no | yes, when __________ | Jaundice, liver disease, liver failure, Hepatitis Type____, pancreatitis, chronic diarrhea, bloody stools, black stools |
| no | yes, when __________ | Kidney or urinary tract disease, strictures, renal failure or dialysis |
| no | yes, when __________ | Diabetic, use insulin, insulin pump or oral hypoglycemics, thyroid disease, adrenal disease or other hormonal imbalance |
| no | yes, when __________ | Tendency to bruise or bleed, low platelets, hemophilia, leukemia, Hodgkins disease, unusual blood type, blood tranfusions, blood borne disease |
| no | yes, when __________ | Immunocompromised state, HIV, AIDS, use immunosuppressive medications, antiviral drugs, Prednisone or steroids |
| no | yes, when __________ | Autoimmune disease, rheumatoid arthritis, lupus, myasthenia gravis, multiple sclerosis, scleroderma |
| no | yes, when __________ | Total joint replacement- Shoulder, Hip, Knee, Ankle Left______ Right______ |
| no | yes, when __________ | Mastectomy Left_____ Right____<br>Lymphedema or swelling in either arm Left____ Right____ |
| no | yes, when __________ | Blood thinners: Coumadin, Heparin, Lovenox, Plavix, Aspirin, Persantin,<br>Last Dose:________________________________________________________ |
| no | yes, when __________ | Use of Alcohol, Narcotics, Cocaine, Amphetamines, Valium, Intravenous Drug Use<br>other:____________________________________________________________ |

**Other:** ______________________________________________

**ALLERGIES:** ______________________________________________

______________________________________________

Are you allergic to medications, tape, latex or iodine solution? ______________________________

List any prescription or over the counter medications you have been taking :

**Name of Medication**

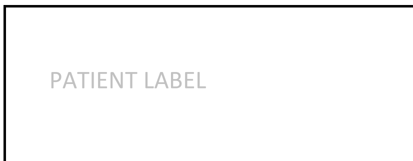
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

| | | | | | |
|---|---|---|---|---|---|
| Wear contact lenses? | no ___ | yes ___ | Use a hearing aid? | no ___ | yes ___ |
| Wear dentures, partials, or caps? | no ___ | yes ___ | Other removable prosthesis? | no ___ | yes ___ |

Patient Signature: ______________________ **Date:** ____________________

Anesthesiologist Signature: ______________________

Nurse Signature: ______________________




Pain Assessment:______________________
(scale 1-10)

Preferred Pharmacy: ______________________