Pre-operative Patient Questionnaire

Patient Identification

Patient Name

Date of Birth

Date of Surgery

Surgeon

NOTE: To be completed by patient and returned to surgeon's office

Check the correct box for each question.

No	Yes	
☐	☐	Have you ever had a heart attack?
☐	☐	Do you ever have chest pain or angina?
☐	☐	Do you have high blood pressure?
☐	☐	Do you have pacemaker / rhythm problems?
☐	☐	Do you have sleep apnea?
☐	☐	Do you have a cough, asthma, bronchitis or emphysema?
☐	☐	Do you get short of breath climbing one flight of stairs?
☐	☐	Do you smoke? How many cigarettes per day? ______
☐	☐	Do you drink alcohol?
☐	☐	Any history of liver disease, jaundice or hepatitis?
☐	☐	Any indigestion, heartburn or hiatus hernia?
☐	☐	Do you have any kidney trouble?
☐	☐	Do you have diabetes?
☐	☐	Any history of thyroid problems?
☐	☐	Any numbness or weakness of arms or legs?
☐	☐	Any history of epilepsy, stroke, TIA?
☐	☐	Have you or members of your family had problems with anesthetics?
☐	☐	Do you have any capped, loose or false teeth?
☐	☐	Any chance you could be pregnant?
☐	☐	Do you bruise or bleed easily?

List your allergies: ____

List your medications: ____

List any operations you have had: ______________________________________

Additional information for the anesthetist/health care provider (for example, if you are seeing a heart doctor, lung doctor or other specialist, please list and inform your surgeon or nurse): ____

____

Completed by: ____________________________ If not the patient, state relationship: _________

print your name

____________________________ Date: _____________

your signature