DE LA VINA SURGICENTER

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____ Lymphedema or swelling in either arm Left____ Right____
no	yes, when _____	Blood thinners: Coumadin, Heparin, Lovenox, Plavix, Aspirin, Persantin, Last Dose:_____
no	yes, when _____	Use of Alcohol, Narcotics, Cocaine, Amphetamines, Valium, Intravenous Drug Use 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 ___

What is your preferred language:

English_____ Spanish_____ other_____

What is your preferred method of learning?

Verbal _____ Written_____ Pictures_____

Patient Signature: _____ **Date:** _____

Anesthesiologist Signature: _____

Nurse Signature: _____

PATIENT LABEL

Pain Assessment:_____

(scale 1-10)

Preferred Pharmacy: _____