

PRE-OPERATIVE HEALTH QUESTIONNAIRE

Please take a moment to complete the attached questionnaire. This will assist our office with your upcoming procedure. If you have any questions about filling out this form, please let us know.

Name: _____ DOB: _____
 Height: _____ Weight: _____ lbs

Do you have an allergy/sensitivity to Latex: No Yes
 Do you have ANY allergies: No Yes – List all allergies: _____

List ALL medications you have been taking in the past 3 months: _____

Yes	No	History Of
		Complications with Anesthesia
Explain:		
		Cardiovascular Disease
		Anitcoagulant Therapy (Coumadin, Plavix, Enoxaparin, Heparin, etc)
		Activity Intolerance
		Hypertension/High Blood Pressure
		Irregular Pulse/Murmur
		Chest Pain/Angina
		Asthma
		Sleep Apnea
		Use of CPAP mask/machine
		Respiratory Problems
		Kidney/Urinary
		Diuretic Medications (Water Pill, Lasix, Hydrochlorothiazide, Diazide, etc)
		Diabetes - Insulin
		Diabetes - Diet Managed
		Diabetes - Oral Meds
		Liver Disease/Cirrhosis
		Hepatitis
		Gastrointestinal
		Ulcers

Yes	No	History Of
		Blood Disorder
		Anemia
		Bleeding Problems
		DVT/Blood Clots/Pulmonary Embolus
		Immune Disease
		High risk act for AIDS/HIV
		Cancer
		Chemo/Radiation Treatment
		Suspected Pregnancy
		Neck Pain/Stiffness/Problems
		Back Pain
		Stroke
		Recent Infection
		Dental Dentures/Implants/Loose teeth
		Vision - Contacts/Glasses
		Hearing Problems
		Alcohol/Drug Addiction
		Alcohol Use
		Recreational/Herbal Drug Use
		Smoking - Current
		Smoking - History

Please explain history: _____

Previous surgeries: _____

Do have a Pacemaker/Defibrillator: No Yes – Manufacturer: _____

Patient Signature: _____ Date: _____