PRESTON SURGERY CENTER

Patient Questionnaire (to be completed by patient, family member or responsible party)

Please complete and check any problems you may have, or have had, in the past:

___ High Blood Pressure
___ Heart Disease
___ Heart Attack
___ Chest Pain/ Angina
___ Rheumatic Fever
___ Bleeding Disorder
___ Hemophilia
___ Bleed/ Bruise Easily
___ Asthma
___ Breathing Problems
___ Bronchitis
___ Tuberculosis

___ Emphysema
___ Chronic Cough
___ Recent Wt. Loss
___ Anemia
___ Blood Transfusion
___ Recent Flu/ Cold
___ Stroke
___ Fainting/ Blackouts
___ Seizures
___ Mental Disorder
___ Migraine Headaches
___ Blood Disorder

___ Nerve Injury
___ Paralysis
___ Back/ Neck Injury
___ Herniated Disc
___ Diabetes
___ Thyroid Problems
___ Steroid Use
___ Liver Problems
___ Hepatitis
___ HIV/ AIDS
___ Hiatal Hernia/ Ulcers
___ Frequent Heartburn

___Kidney Problems
___ Arthritis
___ Cancer
___ Chemotherapy
___ Radiation Therapy
___ Loose/ Chipped Teeth
___ Dentures/ False Teeth
___ Neck Pain/ Stiffness
___ Hoarseness
___ Diff Opening Mouth
___ Immunizations

History of: __MRSA Treatment Date:_____ current lesions, ___Yes___ No location:_____
__C Diff Date:_____ current symptoms, describe:_____
__VRE Date:_____ current symptoms, describe:_____
__ Shingles Date:_____ current lesions, ___ Yes___ No location:_____

Tobacco Use ___ Yes ___ No Amount: _____ How Many Years _____ Last Use _____
Alcohol Use ___ Yes ___ No Amount: _____ How Often _____ Last Use _____
Current recreational Drug use: ___ Yes ___No Type:_____
LAST DOSE: _____
Could you be Pregnant? ___ Yes ___ No Date of last Menstrual period: _____
Drug and/ or Food Allergies AND Reactions: _____
Reason for Surgery / Current Medical Problem _____
List all previous Surgeries and Approximate Year: _____
_____
Any problems with previous anesthesia or surgery? ___ Yes ___ No If Yes, please describe:
_____
Family history or problems with anesthesia (ex: High fever, cardiac arrest, MH)? ___Yes ___ No
Comments: _____
List of disabilities: _____
Any bruises, rashes or sores? ___ Yes ___ No If yes, please give locations: _____
List any other ongoing medical problems: _____
_____

I have fully reviewed this questionnaire and answered all questions truthfully and to the best of my knowledge. I am aware that my answers could affect my anesthesia outcome and/ or overall health care.

Patient, Parent or Legal Guardian Signature: _____
Date: _____ Relationship to Patient: _____
NURSE: _____ Telephonic Interview ___ Yes ___ No Date: _____