

Patient Name:
Date of Birth:
Date of Surgery:
Surgeon:

Pre-operative Patient Questionnaire

Check the correct box for each question

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

List your allergies: _____

List your medications: _____

List any operations you 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):
