

SURGERY CENTER QUESTIONNAIRE

Please Answer the Following Questions about your Health History

NOTE: This questionnaire may be used for a second visit,
as long as the information is **UPDATED** and the second visit is **within 30 days** of the first visit.

| Date of 1 st Visit: | | Date of 2 nd Visit: | Date of 3 rd Visit: |
|--------------------------------|----|--|--------------------------------|
| YES | NO | HISTORY | |
| | | MORE INFORMATION, IF ANSWERED "YES" | |
| | | High Blood Pressure | |
| | | <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Failure <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Chest Pain <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Other heart related history - | |
| | | Diabetes | |
| | | Thyroid | |
| | | Lungs <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Other - | |
| | | GI Problems | |
| | | <input type="checkbox"/> Reflux <input type="checkbox"/> Other - <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Yellow Jaundice <input type="checkbox"/> Other - | |
| | | Kidneys | |
| | | <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Other - | |
| | | Bleeding | |
| | | Glaucoma | |
| | | Neuro/Muscular <input type="checkbox"/> Muscle Disorders <input type="checkbox"/> Black Out Spells <input type="checkbox"/> Paralysis <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures/Convulsions Explain - | |
| | | Dental <input type="checkbox"/> Loose Teeth <input type="checkbox"/> False Teeth <input type="checkbox"/> Dentures <input type="checkbox"/> Bridges <input type="checkbox"/> Capped Teeth <input type="checkbox"/> Braces | |
| | | Sleep | |
| | | <input type="checkbox"/> Snoring <input type="checkbox"/> Sleep Apnea | |
| | | Family History | |
| | | Have you had a family member that has had a problem with being put to sleep for an operation? | |
| | | Hospitalizations | |
| | | List any illnesses that required hospitalization - | |
| | | | |
| | | Surgeries | |
| | | List any past surgeries - | |
| | | | |
| | | Social <input type="checkbox"/> Alcohol – Number of times per week <input type="checkbox"/> Tobacco – Number of times per day | |
| | | Pregnancy | |
| | | If female, what was the date of last menstrual cycle - | |
| | | Recent Illness | |
| | | <input type="checkbox"/> Cold/Sinus <input type="checkbox"/> Other - <input type="checkbox"/> Do you wear contacts? <input type="checkbox"/> Do you wear hearing aids? | |
| | | Medications/Allergies | |
| | | NOTE: Complete the back side of this form | |

To be Reviewed by the Healthcare Providers