Pre-Surgery Questionnaire

* If you have wish to expand in any area or have additional information that is important the doctor know please add on to this form.
* YOUR SAFETY DEPENDS ON THE ACCURACY OF THE INFORMATION PROVIDED .

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*Name: |  | | \*Height: | | |  | \*Age: | |  | |  |
| E-mail: |  | | \*Weight: | | |  | \*BMI: | |  | |  |
| Address: |  | | City, state, zip | | |  | | | | | |
| \*Telephone: | Home: | | Maximum Weight: | | |  | When? | |  | | |
|  | Cell : | |
| \*List all Medicine Allergies: |  | | Date of Birth: | | |  | Date of surgery: | |  | | |
| \*Name of person to contact\_(in case of emergency): |  | | \*Emergency\_ Phone #: | | |  | | | | | |
| * \*Any Medical/physical problems (i.e., sleep apnea, high blood pressure, diabetes, high cholesterol, blood diseases, neurological disorders, etc)? | | | | | Yes | | | No | | Do Not Know | |
| If Yes, please list: | |  | | | | | | | | | |
| * Are you currently taking any medications or herbal supplements? | | | | | Yes | | | No | | Do Not Know | |
| If Yes, please list the name, dosage and reason for this medicine): | |  | | | | | | | | | |
| * Is there are history in your family of diabetes, cancer and/or hypertension? | | | | | Yes | | | No | | Do Not Know | |
| If Yes, please indicate which ones: | |  | | | | | | | | | |
| * Any surgeries (i.e., gallbladder, appendix, hernia, heart, etc.)? | | | | | Yes | | | No | | Do Not Know | |
| If Yes, please list: | |  | | | | | | | | | |
| * Do you have any adverse reaction to anesthesia? | | | | | Yes | | | No | | Do Not Know | |
| If Yes, please indicate the reaction: | |  | | | | | | | | | |
| * Do you have dentures, dental implants, or caps? | | | | | Yes | | | No | | Do Not Know | |
| If Yes, please indicate where: | |  | | | | | | | | | |
| * Do you have any children? If so, how many? | |  | |  | Yes | | | No | |  | |
| * Do you have heavy periods? | |  | |  | Yes | | | No | |  | |
| * Do you smoke? If so, how many cigarettes a day? | |  | |  | Yes | | | No | |  | |
| * Do you drink? If so , how many? | |  | |  | Yes | | | No | |  | |
| * Do you do drugs? If so, what kind & how often? | |  | |  | Yes | | | No | |  | |