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 |  |

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