Patient Label

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 1st Visit:			Date of 2nd Visit:	Date of 3rd Visit:
YES	**NO**	HISTORY	**MORE INFORMATION, IF ANSWERED "YES"**	
		High Blood Pressure		
		Heart	□ Heart Attack □ Heart Failure □ Irregular Heart Beat	
			□ Chest Pain □ Mitral Valve Prolapse	
			□ Other heart related history -	
		Diabetes		
		Thyroid		
		Lungs	□ Asthma □ Tuberculosis □ Emphysema	
			□ Chronic Bronchitis □ Other -	
		GI Problems	□ Reflux □ Other -	
		Liver	□ Hepatitis □ Cirrhosis □ Yellow Jaundice	
			□ Other -	
		Kidneys	□ Bladder Infections □ Kidney Stones	
			□ Other -	
		Bleeding	Explain -	
		Glaucoma		
		Neuro/Muscular	□ Muscle Disorders □ Black Out Spells □ Paralysis	
			□ Stroke □ Seizures/Convulsions	
			Explain -	
		Dental	□ Loose Teeth □ False Teeth □ Dentures	
			□ Bridges □ Capped Teeth □ Braces	
		Sleep	□ Snoring □ 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	□ Alcohol – Number of times per week	
			□ Tobacco – Number of times per day	
		Pregnancy	If female, what was the date of last menstrual cycle -	
		Recent Illness	□ Cold/Sinus □ Other -	
		Vision/Hearing	□ Do you wear contacts?	
			□ Do you wear hearing aids?	
		Medications/Allergies	**NOTE: Complete the back side of this form**	

To be Reviewed by the Healthcare Providers