Medical Patient Questionnaire

Name: ____Date of Birth: ________________Age:___________

Phone: Home_____________________ Cell ___________________________ Work ________________________

WHICH NUMBER DO YOU PREFER WE CALL: □ HOME □ CELL □ WORK
MAY WE LEAVE A MESSAGE ON YOUR CELL OR HOME MACHINE: □ YES □ NO
WHO MAY WE SPEAK WITH ABOUT THE UPCOMING PROCEDURE? _______________________________________
RELATIONSHIP: □ SPOUSE □ CHILD □ OTHER: ____
WHO WILL BE STAYING WITH YOU FOR THE FIRST 24 HRS AFTER THE PROCEDURE? __________________________
IS ENGLISH YOUR PRIMARY LANGUAGE? □ YES □ NO IF NO, WHAT IS _________________________________

PLANNED SURGERY: ____

PRIMARY CARE DOCTOR: ____PHONE:_______________________

DO YOU HAVE A LIVING WILL? □ YES □ NO IF YES, PLEASE BRING ALONG

DO YOU HAVE A GUARDIAN OR A MEDICAL POWER OF ATTORNEY? □ YES □ NO IF YES, WHO _____________

WEIGHT________ HEIGHT _________ ________ BMI (WASC STAFF WILL CALCULATE)

HAVE YOU EVER HAD ANY OF THE FOLLOWING? □ MRSA □ VRE □ C-DIFF □ HEPATITIS □ TB □ NONE

ALLERGIES AND REACTIONS: □ NONE □ SEE MED REC

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____

MEDICATIONS/SUPPLEMENTS/OVER-THE-COUNTER MEDICATIONS: □ NONE □ SEE MED REC

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____

PREVIOUS SURGERIES: □ NONE

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____

TESTING: □ NONE
□ RECENT EKG: WHEN/WHERE: ______________________ □ OLD EKG: WHEN/WHERE: ___________________
□ RECENT LAB: WHEN/WHERE: ______________________ □ OLD LAB: WHEN/WHERE: ___________________

<u>ANESTHESIA PROBLEMS</u> □ NONE
□ DIFFICULT INTUBATION
□ FAMILY OR PERSONAL HISTORY OF MALIGNANT HYPERTHERMIA OR PARALIZED 24 HRS AFTER ANESTHESIA
□ Other: ____

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MEDICAL HISTORY:

CARDIAC: □ NONE
□ HYPERTENSION- TYPICAL B/P _______ □ CONTROLLED □ NOT CONTROLLED
□ CATH OR STRESS TEST WHEN_____________________ WHERE ______________________
□ CARDIOLOGIST ___________________LAST SEEN__________WHERE_____________ FOR__________________
*** IF NONE OF THE ABOVE, GO TO NEXT SECTION
□ ECHO WHEN_____________________ WHERE ______________________
□ CARDIAC STENTS NUMBER_____ WHEN_____________________ WHERE ______________________
□ PACEMAKER/DEFIBRILLATOR WHEN_____________________ LAST CHECKED________________
□ RHYTHM DISTURBANCE □ A-FIB □ A-FLUTTER □ SVT □ OTHER____________________________
□ PRIOR HEART ATTACK □ HEART DISEASE □ CONGESTIVE HEART FAILURE
□ CHEST PAIN □ LEG/FOOT SWELLING □ VASCULAR DISEASE
□ OTHER ____

RESPIRATORY: □ NONE
□ PULMONOLOGIST___________________LAST SEEN__________WHERE_____________ FOR________________
□ ASTHMA □ COPD/EMPHYSEMA □ LAST FLARE UP: __________ LAST ADMIT OR ER VISIT: ________
□ WHEEZING □ SHORT OF BREATH □ RECENT COLD/URI □ SINUS
□ SNORES/OBSTRUCTS WITH SLEEP
□ SLEEP APNEA C-PAP _____ mmHG WEARS □ SOMETIMES □ ALWAYS □ NEVER

ADDITIONAL HISTORY: □ NONE
□ DIABETES □ DIET CONTROLLED □ ORAL MEDS □ INSULIN □ HOW MANY YEARS? ____ __
□ REFLUX □ CONTROLLED □ NOT CONTROLLED
□ SEIZURE DISORDER LAST SEIZURE: __________________
□ BLEEDING DISORDER OR CLOTTING DISORDER (DVT/PE) TYPE: ______________________ □ FAMILY HISTORY
□ THYROID PROBLEMS □ HYPO □ HYPER
□ TIA OR STROKE WHEN_____________________ BODY PART EFFECTED __________
□ KIDNEY DISEASE □ DIALYSIS
□ CANCER □ RADIATION □ CHEMO WHEN_____________________
□ STEROID USE WITHIN THE LAST TWO WEEKS: □ YES □ NO DESCRIBE: _________________________________
□ ANY OTHER MEDICAL PROBLEMS? ____

FEMALES ONLY:
□ LAST MENSTRAL PERIOD _________ □ DOCUMENTED MENOPAUSE/HYSTERECTOMY □ BREAST FEEDING

TOBACCO, **ALCOHOL, DRUGS**: □ YES □ NO DESCRIBE: ___________________________________
ASSISTIVE AIDS: □ GLASSES/CONTACTS □ BLINDNESS □ HOH/DEAF □HEARING AIDS □ WALKER/WHEELCHAIR
LOOSE TEETH/DENTURES/CAPS: □ YES □ NO DESCRIBE: ___________________________________

SIGNATURE OF PERSON FILLING OUT FORM: ___________________________________**DATE**________________

WASC USE ONLY BELOW THE LINE:
PRE-OP COMPLETED BY: □ **ANESTHESIA: INITIALS**__________ □**NURSING: INITIALS**__________
THE FOLLOWING HAVE BEEN REVIEWED WITH THE PATIENT AND QUESTIONS ANSWERED:
□ PRE-OP INSTRUCTIONS □ CENTER OWNERSHIP □ PT RIGHTS AND RESPONSIBILITES □ ADVANCE DIRECTIVES
SPOKE WITH: □ PT □ OTHER__________________SIGNATURE: ______________________ DATE: ______________
NURSE CHECKING PT IN_________________________DATE____________ □ NO CHANGE
CHANGES LIST: ____

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