PLEASE BRING THIS COMPLETED FORM TO YOUR PREOPERATIVE APPOINTMENT

SURGICAL ADMISSIONS HISTORY QUESTIONNAIRE

IMPRINT AREA

Please complete this form carefully. It will be made part of your medical record and will be confidential.

DATE	NAME (FIRST, MIDDLE, LAST)		
MEDICAL RECORD NUMBER	SEX ☐ Male ☐ Female	BIRTH DATE	AGE

1. PAST MEDICAL HISTORY

A. Childhood

- Did you have the usual childhood diseases (i.e., measles, mumps and chicken pox)? ☐ Yes ☐ No
- Did you have unusual childhood disease (i.e., rheumatic fever, heart disease, leukemia, kidney disease, hormone disorders or tumors)? Please circle and explain.

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- Did you have a full series of tetanus immunizations? ☐ Yes ☐ No
- Date of last booster ______________________________

B. Adult Illnesses

- Please check all medical conditions for which you are now being treated, or for which you have been admitted to the hospital:
  If checked, list date of onset or duration of condition

☐ Thyroid ______________________________
☐ Diabetes ______________________________
☐ High Blood Pressure ______________________________
☐ Heart Attack ______________________________
☐ Heart Failure ______________________________
☐ Stroke ______________________________
☐ Vascular (blood vessel) Disease ______________________________
☐ Tuberculosis ______________________________
☐ Hepatitis ______________________________
☐ Asthma or Emphysema ______________________________
☐ Seizures ______________________________
☐ Other: (Explain) ______________________________

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2. MEDICATIONS

A. Prescription Medications: (List name, dose and how often taken.)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

B. List any nonprescription remedies you take daily or frequently (i.e., aspirin, vitamins, herbal remedies):

______________________________ ______________________________

______________________________ ______________________________

3. OPERATIONS (With dates and hospital, if known):

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4. ALLERGIES TO MEDICATIONS

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5. REVIEW OF SYSTEMS (If yes to any of the following questions, when in recent past? How often?):

A. Cardiovascular: (Check or explain)

- Do you have chest pain, chest tightness or angina on exertion? . . . . . ☐ Yes ☐ No
- Do you have the above symptoms at rest? . . . . . ☐ Yes ☐ No

  If yes, how long does the pain last? ______________________________
- Do you need more than 2 pillows to sleep at night? . . . . . ☐ Yes ☐ No
- Do you wake up at night short of breath? . . . . . ☐ Yes ☐ No
- Do you have frequent fainting or dizzy spells? . . . . . ☐ Yes ☐ No
- Have you been diagnosed with a heart murmur? . . . . . ☐ Yes ☐ No
- Have you been diagnosed with a heart attack? . . . . . ☐ Yes ☐ No
- Have you ever had heart palpitations? . . . . . ☐ Yes ☐ No

B. Respiratory

- Does walking up 2 flights of stairs make you very short of breath? . . . . . ☐ Yes ☐ No
- Do you have frequent yellow or green sputum? . . . . . ☐ Yes ☐ No
- Has there been any change in your voice recently? . . . . . ☐ Yes ☐ No
- Do you have frequent or chronic chest pain? . . . . . ☐ Yes ☐ No
- Do you cough up blood? . . . . . ☐ Yes ☐ No
- Have you ever had phlebitis, or blood clots in your legs? . . . . . ☐ Yes ☐ No
- Have you ever had pneumonia? . . . . . ☐ Yes ☐ No
- Have you ever had asthma? . . . . . ☐ Yes ☐ No

C. Central Nervous System

- Do you have seizures? . . . . . ☐ Yes ☐ No
- Do you have severe headaches? . . . . . ☐ Yes ☐ No
- Do you have temporary changes in vision or hearing? . . . . . ☐ Yes ☐ No
- Have you had any temporary loss of strength or sensation on one side? . . . . . ☐ Yes ☐ No

D. Gastrointestinal

- Have you lost or gained weight over the last several months? . . . . . ☐ Yes ☐ No

  How much? __________
- Do you have frequent nausea, vomiting, diarrhea or constipation? . . . . . ☐ Yes ☐ No
- Have you had a change in bowel habits or stool size? . . . . . ☐ Yes ☐ No

D. Gastrointestinal (cont.)

- Have you ever had black tarry stools? . . . . . ☐ Yes ☐ No
- Have you ever had blood in your stool? . . . . . ☐ Yes ☐ No
- Have you ever had hemorrhoids (piles)? . . . . . ☐ Yes ☐ No
- Have you ever had a hernia (ruptures)? . . . . . ☐ Yes ☐ No
- Have you ever had peptic ulcer disease (stomach ulcers)? . . . . . ☐ Yes ☐ No
- Have you ever vomited blood? . . . . . ☐ Yes ☐ No
- Have you ever had hepatitis (turned yellow)? . . . . . ☐ Yes ☐ No

E. Genitourinary

- Have you ever had cloudy urine? . . . . . ☐ Yes ☐ No
- Have you ever had blood in your urine? . . . . . ☐ Yes ☐ No
- Do you have a burning sensation on urination? . . . . . ☐ Yes ☐ No
- Do you have a history of stones? . . . . . ☐ Yes ☐ No
- Do you get up several times a night to urinate? . . . . . ☐ Yes ☐ No
- (For men) Do you have difficulty initiating urination? . . . . . ☐ Yes ☐ No
- (For women) Do you have any gynecological problems? . . . . . ☐ Yes ☐ No

F. Other

- Do you bleed or bruise excessively or easily, such as after tooth extractions or accidents? . . . . . ☐ Yes ☐ No
- Have you ever required a transfusion? . . . . . ☐ Yes ☐ No
  If yes, when? ____________________ About how many? ____________________
- Do you have any communicable diseases? . . . . . ☐ Yes ☐ No

6. FAMILY HISTORY

- Check any disease(s) that run in your family.
  ☐ Diabetes ☐ High Blood Pressure ☐ Heart Attack ☐ Stroke ☐ Cancer ☐ Bleeding Disorders ☐ Tuberculosis
  ☐ Other: ____________________
- Is there any family history of having problems with anesthesia, such as high blood pressure or high fevers during surgery? . . . . . ☐ Yes ☐ No

7. SOCIAL HISTORY

A. Do you smoke? ☐ Yes ☐ No

Cigarettes? ☐ Yes ☐ No How many packs per day? __________ How long? __________

Cigars? ☐ Yes ☐ No **Pipe?** ☐ Yes ☐ No When will you quit? ____________________

Have you ever smoked? ☐ Yes ☐ No How much? __________ When did you stop? __________

B. Do you drink alcohol? ☐ Yes ☐ No Type? ____________________

How much? ____________________ How often? ____________________

C. Do you use social drugs? (i.e., cocaine, marijuana) ☐ Yes ☐ No

If yes, what kind and how often? ____________________

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D. Do you use products containing caffeine more than 3-5 times a day?
(i.e., coffee, cola, chocolate) ☐ Yes ☐ No

OVER

8. Please state what you hope to achieve with this surgery.

9. Is there any other medical information that you would like us to know?

PLEASE NOTE

1. **Do not take any aspirin or ibuprofen products, such as Motrin®, Advil®, or Medipren®, for 14 days prior to your surgery. These medications increase bleeding. It is fine to take acetaminophen products like Tylenol®.**
2. **Do not diet for one month prior to your surgery. This could impede the healing process.**
3. **Stop smoking.**