PATIENT QUESTIONNAIRE

NAME: ______________________________________	DATE: _________________
PHYSICIAN: _____________________________	Date of Surgery:____________
Surgery Procedure: ____	
Age: ________ Height: ____________ Weight: ____________	Language: English or _______

Latex Sensitivity: Yes No
(Have you ever reacted after exposure to Band-Aids, tape, bandages, elastic, spandex, avocados, bananas, tropical fruit, kiwi, rubber products, surgical gloves, balloons?)
Allergies:
____
____
____

Current Medications: (include Dosage and Frequency) List on page 2
Previous Surgeries:
____
____
____

Previous Hospitalizations:
____
____

Medical History Review:

System	No	Comments
Central Nervous System/Skeletal Stroke Seizure Back/Neck Problems Arthritis Other		
Cardiovascular Hypertension Angina Heart Attack CHF Heart Murmur Pacemaker AICD Other		
Respiratory Asthma Emphysema Bronchitis Recent cold/flu Other		
Gastrointestinal PUD Hiatal Hernia/Reflux Other		
Hematologic Anemia Bleeding Tendency Other		
Miscellaneous Diabetes Liver Disease Kidney Disease Pregnant Glaucoma Other		
Psycho/Social Alcohol How much _________ Smoker How much _______ Street drugs? Specify _____________		
In the past 6 weeks have you been exposed to a communicable disease?		
Have you or any of your family members had any problems with anesthesia?		
Do you have an advance directive?		
Do you wear a hearing aid? Yes or No Do you wear dentures? Yes or No Any caps or loose teeth? Yes or No		

Assessment Information Obtained from: Patient Spouse Parent Other

Patient Signature: ____ Date: __________________

Nurse's Signature: ____ Date: ___________________