Pre-Admission Medical Questionnaire

PATIENT NAME: _____ AGE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____

FAMILY DOCTOR: _____ DATE LAST SEEN: _____

CARDIOLOGIST: _____DATE LAST SEEN: _____

Do you have any allergies to medications: (Circle One) Yes NO If yes, please list the allergies and the reactions you have below:

_____

_____

Circle if you have an allergy or reaction to any of the following: LATEX Contrast Dye Adhesive Tape Iodine Dairy

A. To your knowledge, do you now have or have you ever had any of the following:

Respiratory Problems	**Yes**	**No**	**Cardiovascular Problems**	**Yes**	**No**	**Neurologic Problems**	**Yes**	**No**
Recent cold, Bronchitis, or Pneumonia			Irregular heart beat			Tremors		
Asbestosis			Mitral Valve Prolapse			Parkinsons		
Asthma or Wheezing			Heart Murmur			Stroke or TIA		
Sleep Apnea/Excessive snoring			High Blood Pressure			Multiple Sclerosis		
Use C-PAP/ BiPAP/Home oxygen/Home breathing treatments			Palpitations			Head Injury Year: _____		
Shortness of Breath with exertion or at rest			Heart Attack Year: _____			Neuropathy		
Emphysema / COPD			High Cholesterol			Epilepsy/Seizures		
Chronic Bronchitis			Heart Failure			Migraines		
Chronic Cough or Lung Problems			Chest Discomfort or Tightness			Vertigo		
Tuberculosis/ Year _____			Poor Circulation to feet or legs			Restless Leg Syndrome		
Hematologic Problems	**Yes**	**No**	**Digestive Problems**	**Yes**	**No**	**Endocrine Problems**	**Yes**	**No**
Anemia			Liver Disease/Jaunidice/Hepatitis			Thyroid Disorder		
Sickle Cell or Trait			Chronic Heartburn			Parathyroid Disorder		
History of bleeding or Bruising			GI Bleed or Ulcer			Diabetes		
Blood transfusion Year of 1st transfusion: _____			Hiatal Hernia			Adrenal Disorder		
Blood Clots			Reflux			Pituitary Disorder		
			Crohns Disease			**Urology Problems**	**Yes**	**No**
Mental Health Problems	**Yes**	**No**	Diverticulitis			Kidney Stones		
Anxiety or Depression			IBS or Ulcerative Colitis			Enlarged Prostate		
Panic Disorders			**Dental (Circle One or All)**	**Yes**	**No**	Urinary Retention		
Bipolar Disorder			Caps Implants Crowns			Dialysis		
Schizophrenia			Dentures Full Partial			Stress Incontinence		
Alzheimer's Disease			Veneers Bondings			Urinary Tract Infections		
Dementia			**Skin**	**Yes**	**No**	Urinary Frequency		
Memory Loss			Rashes			**Other Problems**	**Yes**	**No**
Musculoskeletal	**Yes**	**No**	Rosacea			Cancer Where: _____		
Chronic Pain			Open Wounds			HIV		
TMJ			Psoriasis			AIDS		
Arthritis			**Advanced Health Care Directive**	**Yes**	**No**	Cardiac Cath		
Osteoporosis			Do you have an Advanced Directive or Living Will? If yes, please bring a copy to the hospital			Cardiac Stents		
Osteopenia			Do you have a healthcare power of attorney? If yes, please list name and contact info: _____ _____			Pacemaker		

Women's Health	Yes	No	Do you have a financial power of attorney? If yes, please bring a copy and list name and contact info: _____ _____			Pain Screening	Yes	No
Are you Pregnant?						Do you have chronic pain? If yes, Where? _____		
Menopausal						Rate the severity of your pain: _____ (0=no pain, 10=severe pain)		
Date of last period: _____								
Nutritional Screening	**Yes**	**No**	**Substance Screening**	**Yes**	**No**	**Anesthesia Screening**	**Yes**	**No**
Are you on any special diet?			Do you Smoke? If yes, how much? _____			Any previous problems with anesthesia?		
Weight loss of more than 10 pounds over the last 3 months			Do you drink alcohol? If yes, how much? _____			Any family members with problems with anesthesia?		
			Do you use recreational drugs or IV drugs?			Have you or a family member ever had malignant hyperthermia?		
Eyes	**Yes**	**No**	**Ears**	**Yes**	**No**	**Communication**	**Yes**	**No**
Visual Impairments			Hearing deficits			Need for an Interpreter?		
Do you wear glasses or contacts			Do you use hearing aids			What is your primary language? _____		
Cataracts or Glaucoma						What is you preferred language for healthcare? _____		

B. Please list all previous surgeries or procedures requiring anesthesia:

_____

_____

_____

_____

C. Please list all medications and supplements that you are currently taking:

Medication	Dose	Frequency	Time (am/pm)	Purpose

Medication	Dose	Frequency	Time (am/pm)	Purpose

D. Please list all other concerns or questions that you might have?