

## 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 1 <sup>st</sup> Visit:		Date of 2 <sup>nd</sup> Visit:	Date of 3 <sup>rd</sup> Visit:
YES	NO	HISTORY	
		MORE INFORMATION, IF ANSWERED "YES"	
		<b>High Blood Pressure</b>	
		<input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Failure <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Chest Pain <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Other heart related history -	
		<b>Diabetes</b>	
		<b>Thyroid</b>	
		<b>Lungs</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Other -	
		<b>GI Problems</b>	
		<input type="checkbox"/> Reflux <input type="checkbox"/> Other - <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Yellow Jaundice <input type="checkbox"/> Other -	
		<b>Kidneys</b>	
		<input type="checkbox"/> Bladder Infections <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Other -	
		<b>Bleeding</b>	
		<b>Glaucoma</b>	
		<b>Neuro/Muscular</b> <input type="checkbox"/> Muscle Disorders <input type="checkbox"/> Black Out Spells <input type="checkbox"/> Paralysis <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures/Convulsions Explain -	
		<b>Dental</b> <input type="checkbox"/> Loose Teeth <input type="checkbox"/> False Teeth <input type="checkbox"/> Dentures <input type="checkbox"/> Bridges <input type="checkbox"/> Capped Teeth <input type="checkbox"/> Braces	
		<b>Sleep</b>	
		<input type="checkbox"/> Snoring <input type="checkbox"/> Sleep Apnea	
		<b>Family History</b>	
		Have you had a family member that has had a problem with being put to sleep for an operation?	
		<b>Hospitalizations</b>	
		List any illnesses that required hospitalization -	
		<b>Surgeries</b>	
		List any past surgeries -	
		<b>Social</b>	
		<input type="checkbox"/> Alcohol – Number of times per week <input type="checkbox"/> Tobacco – Number of times per day	
		<b>Pregnancy</b>	
		If female, what was the date of last menstrual cycle -	
		<b>Recent Illness</b>	
		<input type="checkbox"/> Cold/Sinus <input type="checkbox"/> Other - <input type="checkbox"/> Do you wear contacts? <input type="checkbox"/> Do you wear hearing aids?	
		<b>Medications/Allergies</b>	
		<b>NOTE: Complete the back side of this form</b>	

To be Reviewed by the Healthcare Providers