CHRISTUS Cabrini Surgery Center

PATIENT QUESTIONNAIRE

Name: _____

Please check YES or NO if you have any of the following diseases/conditions:

	YES	NO		YES	NO		YES	NO
Breathing Problems			**Liver Problems**			**Endocrine Problems**		
Asthma/Bronchitis			Hepatitis/Jaundice			Thyroid Disease		
Recent cold or flu			**Neurological Disorders**			Diabetes		
Chronic Obstructive Pulmonary Disease (COPD)			Stroke/Paralysis			Bleeding Tendency		
Tuberculosis			Epilepsy			Arthritis		
Pneumonia			Seizures					
Sleep Apnea			Severe Headache/Migraine					
Heart Problems			**Bladder Problems**					
Chest pain/angina			Kidney Disease/Failure					
Mitral Valve Prolapse			Urinary Tract Infection					
Heart Attack/heart disease			**Other Problems**					
Congestive Heart Failure			Cancer					
Pacemaker / Defibrillator			HIV/AIDS					
High Blood Pressure			Depression/Anxiety					
Heart caths / Stents			Other:					

1. How tall are you? Feet: _____ inches _____ How much do you weigh? _____lbs.
2. Have you or any blood relatives ever had a problem with anesthetics/anesthesia? **Yes** **No**
   (ex –Malignant Hyperthermia, Pseudocholinesterase deficiency, high fever with anesthesia, etc.)
   If yes, what problem? _____
3. Do you smoke? **Yes** **No** If yes, # packs per day? _____
4. Do you use recreational drugs? **Yes** **No** If yes, what kind? _____
5. Do you drink alcoholic beverages? **Yes** **No** If yes, how much? _____
6. **FEMALE PATIENTS:** Is there any possibility that you may be pregnant? **Yes** **No** **Menopause**
   Date of Last Menstrual Period: _____
7. Do you have the sickle cell trait or disease? **Yes** **No**
8. Do you refuse blood in a life or death situation? **Yes** **No**
9. List all surgeries: _____

_____

I acknowledge that the above information is correct: _____

Patient Signature

CHRISTUS Cabrini Surgery Center
Medication reconciliation form

PATIENT TO COMPLETE MEDICATION SECTION ONLY				
ALLERGIES/REACTIONS:			***For facility use only***	
Medication (include diet pills, herbal remedies, vitamins, and over the counter drugs)	Dose	Frequency	Date last dose taken	(check) to discontinue

Above medication should be continued at home in addition to the prescriptions below unless specified by physician to discontinue as noted above

New medications	Dose	Frequency	Indication / Diagnosis

Instructed patient/family to present this to other healthcare providers.

PreOp	**PACU**
Reviewed day of surgery by: _____ Date: _____ Time: _____	Reviewed by: _____ Faxed to Dr. _____ Date: _____ Time: _____ Information Provided to: ☐ Pt ☐ Family ☐ Other _____