

Folsom Surgery Center

Health Assessment Questionnaire

Please answer all questions and bring this form with you on the day of your surgery.
Your answers will assist us in determining the appropriate anesthetic for your type of procedure.

PATIENT'S NAME: _____

Age: _____ **Gender:** _____ **Weight:** _____ **Height:** _____ **Primary Language Spoken** _____

MEDICAL HISTORY: Fill out to the best of your ability:

Have you had or do you have now:

Heart trouble?	Yes	No	Paralysis?	Yes	No
Heart attack?	Yes	No	Blood transfusion?	Yes	No
Heart murmurs?	Yes	No	Blood clots, phlebitis?	Yes	No
Chest pain?	Yes	No	Stroke?	Yes	No
Irregular heart beat?	Yes	No	Jaundice?	Yes	No
Abnormal EKG?	Yes	No	Hepatitis?	Yes	No
High blood pressure?	Yes	No	Mononucleosis?	Yes	No
Abnormal bleeding?	Yes	No	Low back pain or "disc"?	Yes	No
Lung disease?	Yes	No	Arthritis?	Yes	No
Asthma?	Yes	No	HIV positive results or exposed to AIDS?	Yes	No
Sleep Apnea?	Yes	No	Abnormal chest x-ray?	Yes	No
Diabetes?	Yes	No	Sickle Cell-Trait/disease?	Yes	No
Epilepsy/Seizures?	Yes	No	Dental or oral problems?	Yes	No
Glaucoma?	Yes	No	Visual problems?	Yes	No
Anemia?	Yes	No	Hearing problems?	Yes	No
Kidney disease?	Yes	No	Do you take aspirin or coumadin? Last dose _____	Yes	No
Fracture of facial bones?	Yes	No			
Difficulty opening mouth?	Yes	No			

Please list any medications, including vitamins and herbal supplements, taken on a regular basis.

Please list medications on Patient Medication List on next page.

Please list any allergies. **Do you have a latex allergy?** **Yes** **No**

Please list any chronic illnesses you have:

List previous operations: **Were there any anesthesia complications?** **Yes** **No**

Family history of anesthesia complications? **Yes** **No**

Could you possibly be pregnant? Yes No Do you smoke? Yes No Pks/day _____

Do you have a cold/sore throat? Yes No Drink alcohol? Yes No Amount/week _____

Do you have any questions about your anesthesia and/or surgery? **Yes** **No** **If yes, please state:**

Your Telephone Numbers: Home: _____ **Work:** _____ **Cell:** _____

May we identify ourselves on your telephone answering machine? Yes No

May we identify ourselves to any person answering your telephone? Yes No

Name: _____ **Date:** _____ **Name:** _____ **Date:** _____
(Person filling out questionnaire) (Person reviewing questionnaire)