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.

Abnormal bleeding? Yes No Low back pain or "disc"? Yes No Lung disease? Yes No Arthritis? Yes No HIV positive results or Sleep Apnea? Yes No HIV positive results or Sleep Apnea? Yes No Arthritis? Yes No Diabetes? Yes No Abnormal chest x-ray? Yes No Epilepsy/Seizures? Yes No Abnormal chest x-ray? Yes No Epilepsy/Seizures? Yes No Abnormal chest x-ray? Yes No Glaucoma? Yes No Dental or oral problems? Yes No Anemia? Yes No Dental or oral problems? Yes No Anemia? Yes No Hearing problems? Yes No Kidney disease? Yes No Hearing problems? Yes No Fracture of facial bones? Yes No Do you take aspirin or Coumadin? Last dose Yes No Do you take aspirin or Coumadin? Last dose Yes No Do you have a latex allergy? 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 Family history of anesthesia complications? Yes No Could you possibly be pregnant? Yes No Do you smoke? Yes No Amount/week 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: Way we identify ourselves on your telephone answering machine? Yes No May we identify ourselves to any person answering your telephone? Yes No No Name: Date: Name: Date:	PATIEN	NT'S NAME:									
Have you had or do you have now: Heart trouble? Yes No Blood transfusion? Yes No Heart attack? Yes No Blood transfusion? Yes No Heart attack? Yes No Blood clots, phlebitis? Yes No Chest pain? Yes No Blood clots, phlebitis? Yes No Chest pain? Yes No Blood clots, phlebitis? Yes No Chest pain? Yes No Blood clots, phlebitis? Yes No Chest pain? Yes No Blood pressure? Yes No Daundice? Yes No Abnormal EKG? Yes No Hepatitis? Yes No Chest pain? Yes No Hepatitis? Yes No Chest pain? Yes No Chest pain or "disc"? Yes No Chest pain or "discase? Yes No Chest pain or Discase pain	Age: Gender: Weig		ht: Height:		Primary Lan	Primary Language Spoken					
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Heart trouble? Yes No Blood transfusion? Yes No Heart attack? Yes No Blood transfusion? Yes No Heart murmurs? Yes No Blood transfusion? Yes No Chest pain? Yes No Stroke? Yes No Infections? Yes No Stroke? Yes No Abnormal EKG? Yes No Heart murmurs? Yes No Heart murmurs? Yes No Great Paper No Stroke? Yes No Abnormal EKG? Yes No Heart murmurs? Yes No Hornward heart murmurs? Yes No Glaucoma? Yes No Sickle Cell-Trait/discase? Yes No Glaucoma? Yes No Dental or oral problems? Yes No Kidney disease? Yes No Hearing problems? Yes No Fracture of facial bones? Yes No Hearing problems? Yes No Fracture of facial bones? Yes No Do you take aspirin or Difficulty opening mouth? Yes No commadin? Last dose 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 medications, including vitamins and herbal supplements, taken on a regular basis. Please list medications on Patient Medication List on next page. Please list any elegant? Yes No Do you smoke? Yes No Amount/week Please list any elegant? Yes No Do you smoke? Yes No Amount/week Do you have a cold/sore throat? Yes No Drink alcohol? Yes No Amount/week Were there any anesthesia complications? Yes No Poyou have a cold/sore throat? Yes No Drink alcohol? Yes No Amount/week Work: Cell: May we identify ourselves on your telephone answering machine? Yes No May we identify ourselves on your telephone answering machine? Yes No	Have yo	u had or do you l	nave now	·:							
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