PAIN DIAGNOSTIC & TREATMENT CENTER - PRE-ADMISSION QUESTIONNAIRE

Below are a few questions we would like you to answer. *Please bring the completed form to your appointment.*

Name: _____

List all surgical procedures you have had and the approximate year:

PROCEDURE	YEAR

ALLERGIES & REACTIONS (medications/latex/etc)

Have you, or any of your family members, had a problem with General Anesthesia (going off to sleep for a surgery): YES ____ NO ____
If yes, please explain:

Have you ever been hospitalized for an illness other than a surgical procedure?: YES ____ NO ____ If yes, please explain:

Is there any possibility that you are pregnant?: YES ____ NO ____ If yes, have you notified your surgeon?: YES ____ NO ____

Date of Last Menstrual Period_____

GENERAL HEALTH

Do you have, or have you ever had, any of the following?

	YES	NO		YES	NO
NERVOUS SYSTEM			**LUNGS**		
Seizures and/or epilepsy	☐	☐	Pneumonia or bronchitis	☐	☐
Strokes	☐	☐	Asthma or wheezing	☐	☐
Blackout spells	☐	☐	Tuberculosis	☐	☐
Paralysis or weakness	☐	☐	Shortness of breath	☐	☐
Use Recreational Drugs	☐	☐	Smoker	☐	☐
Drink Alcohol	☐	☐	Emphysema / COPD	☐	☐
			Sleep Apnea	☐	☐
HEART AND BLOOD VESSELS			**ABDOMEN - G.I.**		
High blood pressure	☐	☐	Kidney disease	☐	☐
Heart attack	☐	☐	Ulcers	☐	☐
Heart failure	☐	☐	Hiatal hernia	☐	☐
Heart murmur / mitral valve prolapse	☐	☐	Hepatitis	☐	☐
Chest pain / Irregular heart beat	☐	☐	Diabetes	☐	☐
Phlebitis / Blood clots	☐	☐	Thyroid Disease	☐	☐
Any bleeding problems	☐	☐	Other abdominal problems	☐	☐
Pacemaker	☐	☐	Any special bowel / bladder needs	☐	☐
			Gastric Reflux Disease	☐	☐
OTHER			**OTHER**		
Cancer	☐	☐	Growth or developmental delays	☐	☐
Glaucoma	☐	☐	Diagnosed syndromes or diseases	☐	☐
Orthopedic Limitations	☐	☐	**Communicable Diseases: MRSA or VRE**	☐	☐

Comments/Explanations: _____

Post Procedure Contact Number: _____

Reviewed by:_____ Date:_____ Time:_____

Patient Sticker