**Select Surgical Center at Kennedy** **Pre-Procedure Assessment**

**Patient Name: _____ Date of Birth: _____**

## Patient Medical History Questionnaire

**M F**

**Height: _____Weight: _____lbs. BMI: _____ Allergies: _____**

**Driver Contact Name_____**

**Patient Contact #_____**

**Procedure: _____** **Left Right Bilateral N/A**

| | **Have you ever had the following:** | Yes | No | Comments |
|---|---|---|---|---|
| 1 | You or anyone in your family had a major problem with anesthesia? | | | |
| 2 | You or anyone in your family ever have malignant hyperthermia? | | | |
| 3 | Sleep Apnea? If yes, do you use a CPAP or Bi-PAP machine? | | | |
| 4 | Lung Disorders- Asthma, Emphysema, Bronchitis, COPD? | | | |
| 5 | Have you ever smoked? If yes, how much and how long? | | | |
| 6 | Short of breath after walking up flight of stairs? | | | |
| 7 | Problems turning your neck or opening your mouth? | | | |
| 8 | Loose teeth or dentures? | | | |
| 9 | High Blood Pressure? | | | |
| 10 | Chest pain, heart problems, heart attack, irregular heart rhythm? | | | |
| 11 | Pacemaker, defibrillator, or any implanted devices? | | | |
| 12 | Diabetes? If yes, are you insulin dependent? | | | |
| 13 | Heartburn, acid reflux, hiatal hernia? | | | |
| 14 | Thyroid or hormone deficiencies? | | | |
| 15 | Liver disease, hepatitis, kidney disease, kidney failure? | | | |
| 16 | Stroke, mini-strokes, weakness or paralysis, migraines? | | | |
| 17 | Seizures, epilepsy? | | | |
| 18 | Excessive bleeding tendency or a blood clotting disorder? | | | |
| 19 | Could you be pregnant? LMP: | | | |
| 20 | Do you drink alcohol? If yes, how often: | | | |
| 21 | Any recreational drugs? If yes, type and frequency? | | | |
| 22 | Any other medical conditions? Please list in comments. | | | |
| 23 | Previous Surgeries Please circle all that apply:<br>Appendix, Back, Breast, Carpal Tunnel, Cataract, Colonoscopy, Gallbladder, Gynecological, Heart Bypass, Heart Stents, Hernia, Knee, Hip or Shoulder surgery, Sinus surgery, Tonsils, Total joint replacement, Upper endoscopy, Vascular | | | |
| 24 | Other Surgeries? Please list in comments. | | | |

**Notes Concerning above conditions or surgeries:**

_____

_____

_____

**FORM COMPLETED BY**: PATIENT ☐ FAMILY ☐ NURSE: _____

**Reviewed by Nurse:** _____ Date: _____Time: _____