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PATIENT PRE-ADMISSION QUESTIONNAIRE

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Procedure: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Phone #: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Proposed Procedure: \_\_\_\_\_  
 Surgeon: \_\_\_\_\_  
 Family Doctor: \_\_\_\_\_

◆ Do you have any allergies or sensitivities to drugs, dyes, any kind of tape, latex products, foods, etc? .....  YES  NO  
 If YES, to what? \_\_\_\_\_

What type of reaction?:  
 RASH  HIVES  NAUSEA  SWELLING  TROUBLE BREATHING

◆ Do you take any medicines every day? (Including Aspirin, Birth Control Pills, Maalox.) . *If yes, Please list below and bring to the hospital:*  YES  NO

\_\_\_\_\_  
 \_\_\_\_\_

◆ Do you take any herbal products, diet pills, over-the-counter products?.....  YES  NO  
 If YES, what? \_\_\_\_\_

**NOTE: If you currently are taking herbal / diet remedies, we recommend they be stopped 2 weeks prior to your procedure date.**

◆ Could you be pregnant? .....  YES  NO

◆ Have you ever smoked cigarettes? .....  YES  NO  
 a. How many a day? \_\_\_\_\_ b. For how long? \_\_\_\_\_ c. Do you smoke now? \_\_\_\_\_

◆ Do you drink alcohol? .....  YES  NO  
 a. How often? \_\_\_\_\_ b. What kind? \_\_\_\_\_ c. How much? \_\_\_\_\_

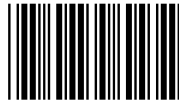
◆ Have you ever had an operation before? .....  YES  NO  
 a. If YES, what kind and when? \_\_\_\_\_

b. Do you remember what type of anesthesia you had? .....  YES  NO  
 General  Spinal  Epidural  Local

c. Did you ever have a problem with anesthesia? .....  YES  NO  
 If YES, what? \_\_\_\_\_

d. Has anyone in your family ever had a problem with anesthesia? .....  YES  NO  
 If YES, what? \_\_\_\_\_

◆ Have you ever had a : heart attack? .....  YES  NO  
 heart condition? .....  YES  NO  
 Have you ever experienced: chest pain (angina)? .....  YES  NO  
 high blood pressure? .....  YES  NO  
 shortness of breath? .....  YES  NO  
 pressure in your chest? .....  YES  NO  
 palpitations or irregular heart beat? .....  YES  NO  
 abnormal electrocardiogram? .....  YES  NO



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- ◆ Do you snore? .....  YES  NO
- Do you suspect or have you been diagnosed with Sleep Apnea?.....  YES  NO
- Have you had sleep studies performed? .....  YES  NO
- Do you wake at night short of breath? .....  YES  NO
- Do you have difficulty breathing while climbing stairs? .....  YES  NO
- Have your lungs ever filled with fluid? .....  YES  NO
- Can you lie flat in bed without getting short of breath? .....  YES  NO
- Has anyone ever told you that you have a heart murmur or that you need antibiotics before you have dental work? .....  YES  NO
- ◆ Have you seen a cardiologist within the last year? .....  YES  NO
- If **YES**, inform him / her of your impending surgery and obtain a note regarding your condition and copies of cardiac testing, including stress and echo tests.
- Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Address: \_\_\_\_\_

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- ◆ Do you have a history of asthma, pneumonia, bronchitis, wheezing, or tuberculosis? .....  YES  NO
  - Have you ever had an abnormal chest X-ray? .....  YES  NO
  - Do you cough daily? .....  YES  NO
  - Have you had a recent cough or cold? .....  YES  NO
  - ◆ Have you seen a lung specialist within the last year? .....  YES  NO
  - If **YES**, inform him / her of your impending surgery and obtain a note regarding your
  - Name: \_\_\_\_\_ Phone: \_\_\_\_\_
  - Address: \_\_\_\_\_

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- ◆ Do you have any problems with your liver? .....  YES  NO
  - Have you ever had hepatitis or jaundice? .....  YES  NO
  - Do you have ulcers, gastritis, hiatal hernia, heartburn, or regurgitation? .....  YES  NO
  - Do you have diabetes or trouble with your blood sugar? .....  YES  NO
  - Do you have trouble with your thyroid? .....  YES  NO
  - Have you ever had kidney trouble or kidney stones? .....  YES  NO
  - Have you ever had a seizure, stroke, dizziness, fainting spells, or a weakness in your arms or legs? .....  YES  NO
  - Do you have anemia (low blood), bleeding problems, frequent nose bleeds, blood clots, or bruise easily? .....  YES  NO
  - Do you or a member of your family have sickle cell anemia? .....  YES  NO
  - Do you have cancer or have you received radiation or chemotherapy? .....  YES  NO
  - Have you ever had a blood transfusion? .....  YES  NO

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- ◆ Any medical conditions we did not ask you about?.....  YES  NO
  - If Yes, what?

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

NOTE TO PHYSICIAN'S OFFICE

**Please ensure this form is forwarded to the West Hartford Surgery Center Pre-Admission Testing Center.**

**Prior to this date: \_\_\_\_\_**

**FAX:860- 231-6185 or Phone:860-586-8655**