

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## PATIENT MEDICAL HISTORY QUESTIONNAIRE

Date of Procedure: \_\_\_\_\_ Surgeon: \_\_\_\_\_ Age: \_\_\_\_\_ M ☐ F ☐  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI Score: \_\_\_\_\_ Preferred Contact Number: \_\_\_\_\_  
 Procedure: \_\_\_\_\_ Left ☐ Right ☐ Bilateral ☐ N/A ☐

## PAST MEDICAL HISTORY

Have you ever had a history of 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 had malignant hyperthermia?			
3.	Sleep apnea? If yes, do you use a C-Pap machine?			
4.	Lung Disorders- Asthma, Emphysema, bronchitis, COPD?			Bring your inhaler.
5.	Have you ever smoked? If yes, how much and how long?			
6.	Can you walk up a flight of steps without getting short of breath?			
7.	Problems turning your neck in all directions 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 implanted heart devices?			
12.	Diabetes? If yes, are you insulin dependent?			
13.	Heartburn, acid reflux or hiatal hernia?			
14.	Thyroid or hormone deficiencies?			
15.	Liver disease, hepatitis, kidney disease, kidney failure?			
16.	Stroke, Mini-Stroke, weakness or paralysis?			
17.	Seizure or epilepsy?			
18.	Excessive bleeding tendency or a diagnosed blood disorder?			
19.	Could you be pregnant? Last period _____			
20.	Do you drink alcohol? If yes, how often _____			
21.	Any recreational drug use? If yes, type and frequency _____			
22.	Any other medical conditions? Please list in comments.			
23.	<b>Previous Surgeries: Please circle all that apply.</b>			
	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:

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Reviewed by Nurse: \_\_\_\_\_ Date: \_\_\_\_\_