Date of Procedure____________

Same Day Surgery Pre Assessment Questionnaire

Dear Patient,

Please answer the questions on this questionnaire and return it ~~before leaving the physician's office today. The office will return it to us~~. If you have any questions please contact Same Day Surgery at 410-543-7037. Since it may be necessary to contact you prior to your procedure, please list your contact phone numbers:

Home:____________________ Work:____________________ Cell:____________________

To protect your privacy no messages will be left on recorders. Thank you.

Patient's Name:________________________________ Social Security #____________________

Type of Procedure you are having:____

Who is providing transportation home? Name:____

1. What medications do you take? List name, amount, how often & reason:

1.____________ 6.____________
2.____________ 7.____________
3.____________ 8.____________
4.____________ 9.____________
5.____________ 10.____________

2. Are you taking herbal or vitamin supplements?

Yes ☐ No ☐ If yes, please list:

1.____________
2.____________
3.____________
4.____________

(Please bring all medications in their containers at the time of your surgery)

3. Have you ever had surgery in the past? Yes ☐ No ☐ (If necessary, use separate sheet of paper)

1.____
2.____
3.____
4.____

4. Do you have any medical condition you feel your Anesthesiologist should know about? Yes ☐ No ☐

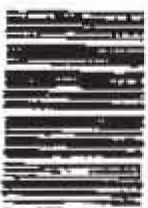
If yes, please list/explain: 1.____________ 3.____________
2.____________ 4.____________

5. Are you allergic to any drugs? Yes ☐ No ☐ If yes, please list medication name & reaction)

1.____________ 3.____________
2.____________ 4.____________

6. Do you have any latex allergies? Yes ☐ No ☐ Food Allergies?____________________

7. Have you had x-rays done in which dye was used? Yes ☐ No ☐ If yes, Did you have a reaction to the dye? Yes ☐ No ☐



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Patient's Name:________________________________ Social Security #________________

Same Day Surgery Pre Assessment Questionnaire Continued

8. Do you have a history of:
   a. Chronic headaches Yes ☐ No ☐
      Stroke Yes ☐ No ☐
      Seizures Yes ☐ No ☐
   b. Heart Problems: Yes ☐ No ☐
      1. Chest pain Yes ☐ No ☐
      2. Shortness of breath Yes ☐ No ☐
      3. Rheumatic fever Yes ☐ No ☐
      4. Heart Attacks Yes ☐ No ☐
      5. Heart Surgery Yes ☐ No ☐
      6. Recent Lipid Profile (for cholesterol) Yes ☐ No ☐
   c. High Blood Pressure Yes ☐ No ☐
      Low Blood Pressure: Yes ☐ No ☐
   d. Respiratory problems: Yes ☐ No ☐
      1. Shortness of breath Yes ☐ No ☐
      2. Asthma Yes ☐ No ☐
      3. TB Yes ☐ No ☐
      4. Emphysema Yes ☐ No ☐
      5. Cough with phlegm or blood Yes ☐ No ☐
         If yes, please explain________________
   e. History of smoking Yes ☐ No ☐
      year quit______ packs per day____ how many years__
   f. Drink alcohol: Yes ☐ No ☐ If yes, how much?__________
   g. Social Drug Use: Yes ☐ No ☐ If yes, what and how often?________
   h. Diabetes Yes ☐ No ☐
      If yes, controlled with: Insulin ☐ Diet ☐ Pills ☐
   i. Cancer Yes ☐ No ☐
      If yes, what kind?________________________
   j. Thyroid problems Yes ☐ No ☐
   k. Kidney problems Yes ☐ No ☐
   l. Hepatitis Yes ☐ No ☐
   m. Hiatal Hernia Yes ☐ No ☐
   n. Ulcer Yes ☐ No ☐
   o. Glaucoma Yes ☐ No ☐
   p. Cataract Surgery Yes ☐ No ☐
   q. Any history of excessive bleeding Yes ☐ No ☐
   r. Any use of steriods in the last year? Yes ☐ No ☐
   s. Have you had recent: (If yes, please list & date & where done)
      Lab work: Yes ☐ No ☐ ________________
      X-rays: Yes ☐ No ☐ ________________
      EKG: Yes ☐ No ☐ ________________

9. Have you or any family member had problems with anesthesia? Yes ☐ No ☐
   If yes, please explain________________________________

10. In an emergency, do you accept blood transfusions or blood products? Yes ☐ No ☐

11. Females: Date of last period________________
    Are you pregnant? Yes ☐ No ☐
    Have you had past pregnancies? Yes ☐ No ☐
    What form of birth control do you use?________________

12. Have you had all your childhood immunizations? Yes ☐ No ☐

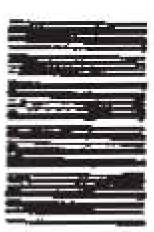
13. Have you had the flu vaccine within the past year? Yes ☐ No ☐

14. Have you had the pneumonia vaccine within the last 2-years? Yes ☐ No ☐

15. Do you wear? Glasses? Yes ☐ No ☐
    Contact Lenses? Yes ☐ No ☐

16. Do you wear dentures? Yes ☐ No ☐
    Any capped or removable teeth? Yes ☐ No ☐

17. Do you have?
    a. Any metal implants? Yes ☐ No ☐ Location of Implant________________
    b. A Pacemaker? Yes ☐ No ☐
    c. Other? Yes ☐ No ☐ Please list________________



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