SURGERY CLINICS HEALTH ASSESSMENT QUESTIONNAIRE

Name:_____ **Age:**_____ **Date:**_____

Weight:_____ **Height:** _____ **Gender:**_____ **Are you Pregnant?:** ☐ Yes ☐ No

Primary Care Provider Name and Number:_____
In the past year, how many times have you been admitted to a hospital? _____

Yes	No	Past Operations	List type of surgery and date:
☐	☐	Have you ever had surgery?	
☐	☐	Any complications with prior surgery?	
☐	☐	Have you ever had anesthesia problems?	
☐	☐	Family history of significant problems with anesthesia?	
Medication Allergies:			

MEDICAL HISTORY – Please mark (x) in appropriate checkbox below (Yes = Past and Present)

Yes	No	Cardiovascular	Yes	No	Cardiovascular
☐	☐	History of heart disease/heart attack	☐	☐	Heart failure
☐	☐	Atrial fibrillation/Heart racing/irregular heartbeat	☐	☐	High blood pressure/ hypertension
☐	☐	Have a heart or blood vessel stent	☐	☐	Heart Murmur/ heart valves problems or surgery
☐	☐	Have a pacemaker or defibrillator	☐	☐	Leg pain when walking
☐	☐	Chest pain: ☐When walking ☐ At rest ☐Now ☐Recently	☐	☐	Swelling in legs/feet ☐Now ☐Recently
Yes	**No**	**Respiratory**	**Yes**	**No**	**Respiratory**
☐	☐	Sleep Apnea ☐ Using CPAP/BiPAP	☐	☐	Use oxygen
☐	☐	Recent Bronchitis/Pneumonia/Virus/Cold	☐	☐	Daily cough/coughing blood/chronic cough
☐	☐	Wheezing	☐	☐	Asthma/COPD/Emphysema
☐	☐	Trouble breathing: ☐During activity ☐At rest ☐Now ☐Recently	☐	☐	Tuberculosis
			Yes	**No**	**Gastrointestinal/Stomach**
Yes	**No**	**Head/Eyes/Ears/Nose/Throat**	☐	☐	Liver disease/ Hepatitis/ Jaundice/ Yellow
☐	☐	Persistent hoarseness	☐	☐	Black stool or blood in stool
☐	☐	Loose/missing/removable teeth	☐	☐	Difficulty swallowing
☐	☐	Mouth/jaw/trouble	☐	☐	Acid reflux/Heart burn
☐	☐	Visually impaired or recent vision changes	☐	☐	Stomach ulcer
☐	☐	Ear or hearing trouble	**Yes**	**No**	**Renal**
Yes	**No**	**Endocrine**	☐	☐	Kidney Disease
☐	☐	Diabetes	☐	☐	Dialysis
☐	☐	Thyroid Issues: ☐Hypo ☐Hyper	☐	☐	Prostate Problems
Yes	**No**	**Hematology**	☐	☐	Urinary Problems
☐	☐	History of bleeding problems	☐	☐	Do you lose control of urine?
☐	☐	History of excessive blood clotting / DVT			

PLACE PATIENT LABEL HERE

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Yes	No	Other/ General	Yes	No	Other/ General
☐	☐	Cancer (any type)	☐	☐	Unexplained fever/night sweats
☐	☐	Organ Transplant	☐	☐	HIV
☐	☐	Persistent skin rash/itching/ skin infection or open wounds	☐	☐	Been treated by a psychiatrist or psychologist in the last year?
☐	☐	MRSA Date:_____	☐	☐	History of Stroke or TIA
☐	☐	Arthritis	☐	☐	History of Seizures
☐	☐	**Can you lay flat and still for 30 minutes (without shortness of breath, coughing or moving)**			

Yes	No	Pain	Yes	No	Pain
☐	☐	Do you have pain that has been present for 3 months or longer?	☐	☐	Do you use a pain pump or stimulator?

Over the past 2 weeks, have you been bothered by these problems: (Please check)

	Not at all	Several days	More days than not	Nearly every day
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Little interest or pleasure in doing things	☐	☐	☐	☐

Yes	No	Well being
☐	☐	Can you walk 4 blocks on flat ground without shortness of breath or chest pain?
☐	☐	Can you walk up 2 flights of stairs?
☐	☐	Do you need help with your self-care at home (ex. Bathing, dressing, cleaning, etc.)?
☐	☐	Do you need help with your daily activities? (ex. Running errands, paying bills, taking medication)?
☐	☐	Do you exercise? Number of times per week? _____ Type: _____
		How many hours of sleep do you get a night? _____
☐	☐	Has your weight changed more than 8 pounds in the last 3 months?
☐	☐	Do you have a poor appetite? How many meals do you eat per day? _____
☐	☐	Have you fallen in the last 3 months?

Social History

Tobacco use: ☐Never ☐Current ☐Past, Quit Year_____ Type: ☐Cigarettes ☐Pipe
If current/past: Number of years_____ Average daily amount_____ ☐Cigars ☐E-cigs

Yes	No	
☐	☐	Do you use methadone/ suboxone/ Buprenorphine/ naltrexone?
☐	☐	Any drug use in last 6 months? (not including marijuana) Which drug(s) _____ If yes: any IV use? ☐No ☐Yes

How often do you drink alcohol? When you drink how many do you have per day? _____
☐Never ☐Less than monthly ☐2-4 times a month ☐2-3 days a week ☐>4 days a week

PATIENT SIGNATURE	PRINT NAME	TIME	DATE

PLACE PATIENT LABEL HERE

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Medications Currently Taking:

Comments:

PATIENT SIGNATURE	PRINT NAME	TIME	DATE

PLACE PATIENT LABEL HERE