PREMIER OUTPATIENT SURGERY CENTER

PATIENT QUESTIONNAIRE

Please complete this form. This questionnaire will become part of your medical record and kept confidential.

FUNCTIONAL ASSESSMENT

☐ No concerns ☐ Confusion ☐ Hearing/Visual impairment
☐ History of prior falls ☐ Impaired mobility ☐ Special equipment (wheel chair etc.)

Comment:

PAST MEDICAL HISTORY Check any of the boxes which describe a health problem you have had in the past:

CARDIOVASCULAR
☐ Chest Pain
☐ Heart Disease
☐ Heart Surgery
☐ Heart Murmur
☐ Heart Attack
☐ Rhythm Problems
☐ Rheumatic Fever
☐ Pacemaker ICD
☐ High Blood Pressure

RESPIRATORY
☐ Shortness of Breath
☐ Asthma
☐ Tuberculosis
☐ Pneumonia
☐ Emphysema
☐ Persistent Cough
☐ Recent Cold
☐ O2 Use _____ XXXX/min.
☐ Inhaler/Respiratory Treatments

GASTROINTESTINAL
☐ Hepatitis
☐ Jaundice
☐ Ulcer
☐ Hernia
☐ Bleeding
☐ Constipation
☐ Diarrhea
☐ You Use Laxatives

GENITOURINARY
☐ Prostate
☐ Kidney
☐ Ostomy
☐ Dialysis
☐ Bladder

NEURO
☐ Strokes
☐ TIA's
☐ Aphasis
☐ Seizures

METABOLIC ENDOCRINE
☐ Thyroid
☐ Diabetes

FOR WOMAN
Could you be or are you now pregnant,
Last Menstrual Period?
_____
☐ Regular ☐ Irregular
☐ Birth Control
☐ Post-Menopausal
☐ Sterilization

E.E.N.T.
☐ Difficulty Swallowing
☐ Difficulty Nose Breathing
☐ Cataracts
☐ Visual
☐ Hearing Problems

MUSCULOSKELETAL
☐ Prosthesis
☐ Stiff Joints
☐ Back/Spinal Surgery
☐ Limitations

HEMATOLOGY/ONOCOLOGY
☐ Anemia
☐ Bleeding Tendencies
☐ Blood Disorder
☐ Cancer
☐ Chemo/Radiation
☐ Vascular Access

NUTRITION
☐ Special Diet
☐ Recent Weight Loss/Gain
☐ Chewing Difficulty
☐ Dentures
☐ Lower ☐ Upper
☐ Partial
☐ Denture Fix Problems

SKIN
☐ Ulcers
☐ Wounds
☐ Rashes

	Yes	No	Frequency
Smoking	☐	☐	_____
Years Quit _____			
Alcohol	☐	☐	_____
Substance Abuse	☐	☐	_____

If yes, please explain: _____

_____

Allergies: ☐ NKDA

MEDICATIONS: (Name, Dose, Frequency)
☐ None

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PREVIOUS SURGERY: (Surgery, Date, Complications)
☐ None

_____
_____
_____

Have you or family members experienced any problems with anesthesia?
☐ None Comments: _____

Do you have any physical limitations? ☐ Yes ☐ No

Explain: _____
_____
_____
_____

_____
Patient Signature

_____
Date

PATIENT IDENTIFICATION LABEL

FORM 406 (Rev. 7/10)