

# VILLAGE SURGICENTER

All questions contained in this questionnaire are strictly confidential  
and will become part of your medical record

## PATIENT DEMOGRAPHICS

<b>Patient Name:</b>		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Day Phone:</b>		<b>Evening Phone:</b>	<b>Cell Phone:</b>
<b>Your Name:</b>		<b>Phone number:</b>	
<b>Relationship to the Patient:</b>			
<b>Patient's primary language:</b>		<b>Will patient need an interpreter:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Will patient bring an interpreter:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Name:</b>	<b>Phone #:</b>

<b>Procedure Date:</b>	<b>Name of Surgeon:</b>
<b>Description of Procedure:</b>	<small>*If you are the legal guardian, have power of attorney or advance directives- please bring documentation</small>
<b>Emergency Contact Name:</b>	<b>Phone Number:</b>
<b>Name of Person Driving you home:</b>	<b>Phone Number:</b>
<b>Name of Person Caring for the patient for 24 hours after surgery:</b>	

Has the patient had any of the following in preparation for surgery? If Yes, please include date and location			
EKG	Yes	No	Where and date of test:
X-Rays	Yes	No	Where and date of test:
Any Blood Tests	Yes	No	Where and date of test:
Other:	Yes	No	Where and date of test:

Describe

Allergies		
Type	If Yes List allergies	Reaction
Drug Allergies		
Food Allergies		
Latex/Rubber Allergies		

Other Allergies		
Other Abnormal Drug Reactions		

ANESTHESIA SECTION		
Do you have motion sickness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had an unusual reactions to Anesthesia such as high temperature, difficulty waking up, nausea, and/or vomiting, or breathing difficulties ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes to any of the above- please explain:		

SURGICAL HISTORY – If none proceed to the next section		
Procedure	Date	
Do you have any implants or prostheses? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Type	Location	Date



Do you have crowns?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have loose or chipped teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Explain:		
Do you wear any retainers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**SKIN**

Do you have any burns? Explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any rashes? Explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any bruises? Explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any other skin conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your skin tear easily?		

**STOMACH**

Do you have ulcers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a hiatal hernia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have acid reflux disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**MENTAL HEALTH**

Have you ever been treated for depression?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you suffer from Anxiety?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you suffer from Panic Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any developmental disorders ? Explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other psychiatric conditions? Explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**NEUROLOGICAL**

Have you ever had a stroke or TIA? If yes – dates:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a seizure? If yes – date of last one:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you suffer from paralysis? If yes - Explain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have Alzheimer's or dementia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have Parkinson's?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any other neurological conditions? If yes- Explain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**MUSCULO-SKELETAL**

Do you have any neck, back or jaw problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes – explain		
Do you have any joint replacement or dislocations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes – explain		
Do you have muscular dystrophy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any other musculoskeletal conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes - explain

**HEMATOLOGICAL**

Have you ever had blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have sickle cell disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any other blood conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes - explain		
Do you bruise easily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you take any blood thinners?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking aspirin or ibuprofen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking Vitamin E?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your family have a history of Hemophilia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes - explain		

**LIVER/KIDNEY**

Do you have jaundice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any cirrhosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have hepatitis? If yes – list type	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you on dialysis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any other urinary problems? Such as urinary retention	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes – explain		

**THYROID**

Do you have hypothyroidism?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have hyperthyroidism?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any other thyroid conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes - explain		

**PAIN**

Pain scale: (0) No Pain (1-2) hurts a little (3-4) Hurts a little more (5-6) Hurts even more (7-8) Hurts a whole lot more (9-10) Hurts the worst



Do you have chronic Pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes; Location:	Pain scale:	How long:
Do you currently have pain associated with the condition for which you are having the procedure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes: Location:	Pain scale:	

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## CARDIOVASCULAR

Do you have or ever had angina /chest pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have low blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have rheumatic fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have congestive heart failure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have mitral valve prolapsed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you have heart surgery/stent/catheter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Explain:	Dates:	
Have you ever had a heart attack?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes: Date(s)		
Do you palpitations or an irregular heart beat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes Explain:		
Do you use a pacemaker/defibrillator?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes: Date(s)	Manufacture:	Date last checked:
Due you to antibiotics prior to procedures? Why:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have high cholesterol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## PULMONARY

Do you have asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have Restrictive airway disease (RAD)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have bronchitis/COPD?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have sleep apnea ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes do you use CPAP? If yes – what is the setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have or have you ever been exposed to Tuberculosis (TB)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use a nebulizer or Home Breathing machine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you ever have shortness of breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you ever smoke/use tobacco ? If yes – packs/day _____ How many years? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you using oxygen at Home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a cold within the past 2 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any other pulmonary conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes – explain:		

## OTHER

Do you drink Alcohol? If yes – How much? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use recreational Drugs? If yes – Explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any body piercings? If yes, Where:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any contagious diseases? If yes - Explain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any type of immunodeficiency ? If yes - Explain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have MRSA?		

Do you have diabetes? If no please continue to next section		
Is your diabetes diet controlled ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use Injectable insulin:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use Oral Medications for your diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use an insulin pump?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have hypoglycemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you check you blood sugar daily? How often?		What is the Range?
	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>WOMEN ONLY</b>		
Date of last menstruation:		
Are you pregnant or trying to become pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>MEN ONLY</b>		
Do you have benign prostatic hypertrophy?		

<b>MINORS</b>		
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Was the patient born pre-mature ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are the patient's immunizations up to date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does any member in the household smoke or use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>PLEASE LIST ANY SPECIAL NEEDS OR CONCERNS</b>		

By submitting this information, the patient or guardian, attest that it is true and accurate to the best of their knowledge.

Reviewed By (Nurse) \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by (Physician) \_\_\_\_\_ Date: \_\_\_\_\_

Revised: 03.08.10