DCR SURGERY CENTER
HEALTH QUESTIONNAIRE

INSTRUCTION TO PATIENT: Please indicate by a (X) your answer to each question. These answers will greatly help our staff to give you the best care during your procedure. If you do not understand any question of your answer is uncertain simply place a (?) in the yes or no column.

Person completing the form: Patient Other________ Relationship___________

Have you had or do you still have any of the following?	**yes**	**no**
Do you smoke PPD___Years___Quit___		
Bronchitis (past 2 weeks)		
Pneumonia (past 2 weeks)		
Emphysema		
Asthma		
COPD		
Tuberculosis		
Sleep apnea		
Shortness of breath		
Any lung problem		
Cardiovascular		
High or Low blood pressure		
Heart failure		
Coronary artery disease		
Heart murmur		
Valve disease		
Chest pain, angina		
Heart attack		

Have you had or do you still have any of the following?	**yes**	**no**
Do you drink alcohol		
Palpitations, irregular or fast heartbeat		
Pace maker		
Easy bruising, excessive bleeding		
Convulsions, epilepsy		
Fainting, blackout spells		
Stroke		
Paralysis, meningitis		
Neuromuscular disease		
Diabetes		
Low blood sugar		
Allergic to **local** anesthetic drug		
Unusual reaction to anesthesia		
Abdominal surgery		
Surgically implanted prosthesis		
Are you pregnant		

List Surgeries_____________________
____
____
____

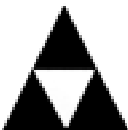
Are you taking Aspirin or blood thinners
Yes_________ No_________
Date last taken__________________

List Allergies (drug or food)__________
____
____
____

Current Meds (include over the counter)
____
____

The above information is correct to the best of my knowledge.

Parent or Guardian___________________________________Date_____________



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