jacksonville beach Surgery Center

Pre-Anesthesia Patient Questionnaire

Patient Name: _____ Primary care physician/phone number: _____

What is your Age? _____ Height? _____ Weight? _____ lbs .BMI?_____

Please list any allergies (including food) and the types of reactions: Anaphylaxis?_____ Latex?_____

Allergy	Reaction	Allergy	Reaction

Please list your current medications, including herbal supplements, vitamins and diet pills:

Medication	Dosage	How often	Medication	Dosage	How often

Please list your previous surgeries/procedures and any complications:

Approx Date	Procedure	Complications	Approx Date	Procedure	Complications

Medical History: Have you EVER had any of the following (Please circle YES or NO)?

***Indicates need for additional information**

Heart or Vascular Problems

Yes	No	High blood pressure or hypertension?
Yes	No	High cholesterol or hyperlipidemia?
Yes*	No	Do you get chest pain or shortness of breath when you climb a flight of stairs or walk up a hill?
Yes*	No	Coronary artery disease, angina (chest pain), heart attack, angioplasty (balloon), cardiac stent?
Yes*	No	*Abnormal* stress test, heart catheterization, echocardiogram (echo), or electrocardiogram (EKG)?
Yes*	No	Congestive heart failure (CHF/Fluid in the lungs)?
Yes*	No	Cardiac arrhythmia or irregular heart beat (atrial fibrillation)?
Yes	No	Pacemaker? *If Yes, please complete Pacemaker-ICD Form upon check in.*
Yes*	No	ICD (implantable cardioverter defibrillator)? *If Yes, please complete Pacemaker-ICD Form upon check in.*
Yes*	No	Severe disease of the aortic or mitral heart valves (aortic/mitral stenosis, aortic/mitral insufficiency)?
Yes*	No	Peripheral vascular disease?