Date: ________________

The Blue Hen Surgery Center
Health Questionnaire

Patient's Name: ______________________________ **Food Allergies/Reaction: ___________________**

Procedure: _________________________________ _______________________________________

Drug Allergies: ______________________________ **Type Reaction: _______________________**

Non Allergic Reaction: _______________________ **Type Reaction: _________________________**

1. Have you ever had a problem with anesthesia? YES NO ______________________________

2. Do you use tobacco products? How Long? YES NO ______________________________

3. Have you had a Recent Cold or Fever? YES NO ______________________________

4. Any history or current use of illegal drug or alcohol abuse? How long? ______ last time you used_____ YES NO ______________________________

5. Do you wear a hearing aid? YES NO ______________________________

6. Do you drink alcohol? If so, how much? YES NO ______________________________

HEART PROBLEMS

7. Have you ever had a heart attack? YES NO ______________________________

8. Have you ever had an irregular heartbeat? YES NO ______________________________

   a. Do you have a Defibrillator or Pacemaker YES NO ______________________________

   b. Heart Murmur that requires antibiotic before procedures? YES NO ______________________________

   c. Mitral valve prolapse? YES NO ______________________________

   d. Do you have Congestive Heat Failure YES NO ______________________________

9. Have you ever had high blood pressure? YES NO ______________________________

LUNG PROBLEMS

10. Do you have a chronic cough? YES NO ______________________________

11. Do you have asthma, emphysema or HX of TB? YES NO ______________________________

12. Do you have sleep apnea? YES NO ______________________________

    a. Do you wear CPAP at night? YES NO ______________________________

13. Have you ever had an abnormal chest x-ray? YES NO ________________________________

KIDNEY PROBLEMS

14. Have you ever had kidney problems? Dialysis? YES NO ________________________________

OTHER PROBLEMS

15. Are you claustrophobic? YES NO ________________________________

16. Have you ever had yellow jaundice?
HIV or hepatitis (liver problems)? YES NO ________________________________

17. Have you had a significant weight loss in the
last four months? YES NO ________________________________

GASTROINTESTINAL PROBLEMS

18. Have you ever had any digestive tract problems? YES NO ________________________________

Hiatal hernia? YES NO ________________________________

Heartburn/Indigestion? YES NO ________________________________

Chronic Diarrhea / Colitis YES NO ________________________________

Stomach Ulcer or Bleeding? YES NO ________________________________

GERD? (Gastroesophageal Reflux Disease) YES NO ________________________________

MUSCULI-SKELETAL PROBLEMS

19. Do you have arthritis? YES NO ________________________________

20. Do you have a limited mobility or difficulty
laying flat? YES NO ________________________________

NEUROLOGICAL (brain/nerves) PROBLEMS

21. Have you ever had scarlet or rheumatic fever? YES NO ________________________________

22. Have you ever had a stroke? YES NO ________________________________

23. Have you ever had epilepsy, seizures, fainting, or
passed out when blood was drawn? YES NO ________________________________

HEMATOLOGIC (blood) PROBLEMS

24. Do you have any bleeding which does not stop
within 2 to 3 minutes? YES NO ________________________________

Next Page

25. Have you ever been anemic (low or thin blood)? YES NO ______________________________

METABOLIC PROBLEMS

26. Do you have diabetes? YES NO ______________________________

Do you have Thyroid problems? YES NO ______________________________

NERVOUS OR EMOTIONAL PROBLEMS

27. Have you ever been treated for depression? YES NO ______________________________
(nerves or anxiety)

GYNECOLOGICAL (women only)

28. Could you be pregnant? (Date of LMP) YES NO ______________________________

MISCELLANEOUS

29. Are you currently taking coumadin? Last dose? YES NO ________________________________
Last PT / INR _______________

30. Are you taking other blood thinners? Last dose? YES NO________________________________

31. Are your taking aspirin? Last dose? YES NO________________________________

32. Are you taking any anti-inflammatory meds? YES NO ________________________________

33. Have you ever had cancer? What type YES NO ________________________________

34. Is there any other Medical history
that wasn't mention? (Stress test, EKG, echocardiogram) YES NO ______________________________

CURRENT MEDS (type, freq & dosage)

SEE ATTACHED DISCHARGE MEDICATION INSTRUCTIONS SHEET FOR CURRENT LIST OF MEDICATIONS.

OVER

SURGICAL HISTORY (type & date):

____

____

____

NURSES NOTES:

____

____

____

____

____

____

____

____

____

____

____

____

____

____

INTERVIEWING NURSE'S SIGNATURE DATE

____

PATIENT'S SIGNATURE DATE

____

REVIEWED BY ANESTHESIA PROVIDER DATE

( ) NO CHANGES SINCE LAST VISIT: ______________________________________

Patients Signature DATE

( ) REVIEWED FOR CHANGES: ____

Nurse's Signature Anesthesia Provider DATE

Updated 12/22/2009