

PRE-OP QUESTIONNAIRE

The following questions are to be answered by or on behalf of the patient scheduled for surgery. If the patient scheduled for surgery presently has, or even has had in the past, any of the following medical conditions, please check "yes" in the appropriate space. Check "no" in the appropriate space for negative answers.

	YES	NO		YES	NO
LUNG			ENDOCRINE		
Born with any lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cough or cold at present time	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease or Goiter	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Have you taken steroids such as cortisone or prednisone with the last year?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	EYE		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Smoke _____ Packs of cigarettes per day for the past _____ years.			Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
HEART			REPRODUCTIVE		
Born with any heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Female: Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	DENTAL		
Rhumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Bridges	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Crowns	<input type="checkbox"/>	<input type="checkbox"/>
Skipped heartbeats	<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	Loose Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Hardening of the arteries	<input type="checkbox"/>	<input type="checkbox"/>	AIRWAY		
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Problem opening mouth wide	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attacks	<input type="checkbox"/>	<input type="checkbox"/>	Problem turning head in any direction	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD			Do you get heartburn when you lie down?	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell trait or disease	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU HAVE ANY PAST OR PRESENT HEALTH PROBLEMS NOT INDICATED ABOVE?	<input type="checkbox"/>	<input type="checkbox"/>
Other disease of blood cells	<input type="checkbox"/>	<input type="checkbox"/>	ANESTHESIC HISTORY		
Abnormal blood clotting	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to any drug used in dental work, anesthesia or surgery	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Any blood relative have any allergy to any drug used in anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY			How many times have you been anesthetized for surgery in the past? _____		
Born with kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Date of last anesthetic _____		
Kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	Any problems resulting from any anesthetic ever administered fo you.	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>			
NERVOUS SYSTEM					
Born with nervous system neutrality	<input type="checkbox"/>	<input type="checkbox"/>			
Brain Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Spinal cord disease	<input type="checkbox"/>	<input type="checkbox"/>			
Nerve disease	<input type="checkbox"/>	<input type="checkbox"/>			
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>	<input type="checkbox"/>			

LIST PRESENT MEDICATIONS BELOW: (including vitamins, herbal supplements and over the counter drugs).

COMMENTS:

DRUG ALLERGIES: _____

LATEX ALLERGY: _____

PATIENT'S SIGNATURE _____
(Or Guardian)

DATE _____