

RIVER DRIVE SURGERY & LASER CENTER
(RDSLc)
PRE-OPERATIVE HEALTH QUESTIONNAIRE

PATIENT NAME _____ DATE _____ ASC# _____
 NAME OF YOUR MEDICAL DOCTOR _____ PHONE _____

HAVE YOU EVER HAD:

Y N HEART CONDITION: High Blood Pressure Angina Bypass Surgery if yes _____

Y N LUNG SURGERY? If yes, which lung Left Right

Y N ASTHMA / BREATHING PROBLEMS /TUBERCULOSIS? _____

Y N DIABETES (HIGH SUGAR)? Insulin Dependent Non-Insulin Dependent (NIDDM)

Y N STROKE / SEIZURES / CONVULPTIONS

Y N (CJD) CREUTZFELDT-JAKOB DISEASE

Y N (MRSA) Methicillin resistant staphylococcus aureus? Yes/No. If Yes, did you receive antibiotic treatment?

Y N BLEEDING PROBLEMS/ JAUNDICE/ HEPATITIS/ LIVER PROBLEMS?

Y N (HIV) HUMAN IMMUNODEFICIEENCY VIRUS /AUTOIMMUNE DISEASES? _____

Y N KIDNEY DISEASE Dialysis Shunt, location _____

Y N BREAST SURGERY? Left Right Both

Y N PREVIOUS SURGERY(S) If yes explain _____

Y N A BAD REACTION TO LOCAL OR GENERAL ANESTHESIA?

Y N ALLERGIES OR REACTIONS TO DRUGS/SHELLFISH/IVP DYE/LATEX? If yes please list: _____

Y N TAKE PRESCRIPTION MEDICATIONS? PLEASE LIST

NAME	DOSAGE

Y N ARE YOU PREGNANT? LAST MENSTRUAL PERIOD DATE: _____ X

DO YOU HAVE ANY PAIN? Y N IF YES PLEASE RATE ON THE SCALE (0=NONE 10 =SEVERE)

0 1 2 3 4 5 6 7 8 9 10 >10 IF SO, WHERE? _____

WHAT RELIEVES THE PAIN? _____

DO YOU:

Y N HAVE A PACEMAKER/IMPLANTABLE DEFIBRILLATOR/CARDIOVERTER?

Y N WEAR A HEARING AID?

Y N WEAR CONTACT LENSES?

Y N HAVE DENTURES, CAPS, BRIDGES? PLEASE CIRCLE

Y N SMOKE IF SO HOW MUCH PER DAY?

Y N DRINK ALCOHOL? IF SO, HOW MUCH PER DAY? _____

Y N NEED TRANSPORTATION? Y N DISABILITY/PROSTHESIS

Y N USE WHEELCHAIR, CANE, WALKER, IF SO, PLEASE CIRCLE

TRANSLATION: _____ BY FAMILY MEMBER _____ BY RIVER DRIVE SURGERY CENTER STAFF _____ SAME AS PREVIOUS

EMERGENCY CONTACT: NAME _____ # _____

Y N I AUTHORIZE RDSLc TO CONTACT MYSELF, ANSWERING MACHINE, OR EMERGENCY CONTACT AS NEEDED.

PATIENT'S SIGNATURE _____ REVIEWED BY (RN/LPN/OT SIGNATURE) _____

DATE _____