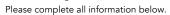
Pre-Operation Questionnaire





Patient Informati	on							
Patient Name:			Date of E	Birth:				
Doctor's Name:			Today's D	Date:				
Preferred Pharmacy:								
Pharmacy Location:								
What body part(s	s) is this visit regarding?							
SHOULDER:	Left Right	ELBOW: Left	Right WF	RIST: Left	Right			
HAND:		HIP: Left	<u> </u>	NEE: Left	Right			
ANKLE:	Left Right	FOOT: Left	Right					
OTHER:								
Please answer all	of the following:							
1. Since your l	ast visit, how are you feeling?			Better	Worse	Same		
2. On a scale	of 0 to 10 (10 is worst), what is	the severity of your pa	in? (circle one): 0 1	2 3 4	5 6 7	8 9 10		
3. Do you have, or have you had, any of the following conditions:								
a.	Heart issues (e.g. high choleste	rol, high blood pressu	ire)	Yes	☐ No			
b.	Do you have a cardiologist?	Yes No	If "Yes," physician's name	:				
c.	History of blood clot(s)			Yes	☐ No			
d.	Breathing problems (e.g. asthm	na, sleep apnea, COPE	D)	Yes	☐ No			
e.	Do you use a CPAP or BiPAP m	nachine?		Yes	☐ No			
f.	Hepatitis or liver trouble			Yes	☐ No			
g.	Kidney problems			Yes	☐ No			
h.	Do you have a nephrologist?	Yes No	If "Yes," physician's name	:				
i.	Epilepsy, seizures, or fits			Yes	☐ No			
j.	Glaucoma			Yes	☐ No			
	Bleeding disorders (e.g. Sickle	•		Yes	☐ No			
l.	Gastrointestinal problems (e.g.	acid reflux, hernia, ulc	cer, heartburn)	Yes	☐ No			
m.	Diabetes	Yes No If	f "Yes," when was last AIC	:				
-	ad any blood drawn or an EKG	-		Yes	☐ No			
	e a history of anesthesia proble			Yes	☐ No			
	e a family history of anesthesia	problems?		Yes	☐ No			
	of pregnancy? (women only)			Yes	☐ No			
	oke (including marijuana)?	∐ Yes ∐ No	If "Yes," how often					
9. Do you drir	ık alcohol?	∐ Yes ∐ No	If "Yes," how much	?				
List all previous surgeries:								
Previous Surgery					Date			
Do you have ar	ny metal in your body?	Yes No	If "Yes," list where	:				

Please complete the reverse side of this form.

List ALL allergies:				
Check if you have allergies to	o: Latex T	ape 🔲 lodine		
Allergy			Reaction	
.				
Liet all madientions in the	dina ayanda a	otor (OTC) modic	otions and supplements	rou are telring.
List all medications inclu	aing over-the-cour	nter (OTC) medic	ations and supplements y	you are taking:
Name of Medication			Dosage	Frequency
Patient Signature:			Data	
			Date:	
MD/PA-C Signature:			Date:	
For Office Use Only				
Blood Pressure:		Pulse:		
Height:	W	/eight:	BMI:	