EHI Pre-Surgical Questionnaire Evaluation

Patient Name: ______________________ **Age**: ________ **Height:** _______ **Weight:** ____________
Best Contact Phone number: ______________________ **Doctor:** ____________________ **Surgery Date**: ________
List All Current Medications (both prescription and over the counter): ______________________

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List all prior surgeries: ______________________
List All Allergies: ______________________

Please Circle YES or NO, If YES Circle Disorder

YES NO Have you ever had problems with anesthesia? Specify ______________________
YES NO Do you have a difficult airway?
YES NO Do you have any allergies to latex, soy, egg, or peanut products?
YES NO Do you have any metal allergies?
YES NO Have you or any family member ever had malignant hyperthermia (i.e. a high fever associated with anesthesia)?
YES NO Do you have any heart problems: High Blood Pressure, Mital Valve Prolapse, Heart disease, Heart Attack, Angina, Atrial Fib?
YES NO Do you have Aortic Stenosis?
YES NO Do you have an abnormal heartbeat?
YES NO Congestive Heart Failure or Cardiomyopathy?
YES NO Do you have a pacemaker or internal defibrillator?
YES NO Do you see a Cardiologist routinely? If Yes How Often? ______________________

Stress Test: YES NO Date: _________ Normal/Passed _______ Abnormal _________
Heart Cath YES NO Normal _________ Mild blockages _________ Angioplasty/Stent_______

Are you on any of the following Blood Thinners or Heart medications?

YES	NO	Coumadin	YES	NO	Eliquis	YES	NO	Brilinta
YES	NO	Plavix	YES	NO	Effient	YES	NO	Pletal
YES	NO	Aggrenox	YES	NO	Pradaxa	YES	NO	Aspirin 81mg
YES	NO	Nitroglycerin	YES	NO	Xarelto	YES	NO	Aspirin 325

YES NO Do you have any gastrointestinal problems including: Hepatitis, Heartburn, Hiatal Hernia, Ulcers, Gallstones?
YES NO Do you have any skin problems including: Herpes, Rashes, Eczema?
YES NO Do you have any blood disorders including: Sickle Cell, Anemia, Mono, Clotting Disorder, Deep Vein Thrombosis?
YES NO Do you have Diabetes? Do you take insulin? ______________________
YES NO Do you have a Thyroid Disorder?
YES NO Do you have any Neurological disorders?
YES NO Have you ever had a Seizure, Stroke, or Aneurysm?
YES NO Epilepsy/Seizures, Are you controlled with medications? ______________________
YES NO Do you have any breathing problems including: Asthma, COPD, or Emphysema, Sleep Apnea?
YES NO Do you use a CPAP machine or Bipap?
YES NO After climbing a flight of stairs, are you short of breath?
YES NO Do you have any kidney problems including: Dialysis, Renal Failure, Urinary Tract Infections, Kidney Stones?
YES NO Do you have any limitations on the use of any joints, especially the neck and jaw?
YES NO Do you have Arthritis?
YES NO Do you have any fractures?
YES NO Do you have Cancer?
YES NO Do you have any infectious diseases or are you a carrier of any infectious diseases?
YES NO Have you ever had a HIV test? If yes, was it positive or negative? ______________________
If YES to any of the above questions please explain: ______________________

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Have you had or do you have any other medical conditions not covered above? ______________________
YES NO Do you smoke? Packs per day? ____________ How many years? ________ If quit, how long ago? __________
YES NO Do you use alcohol? If yes, how much? ______________________
YES NO Do you wear contact lens?
YES NO Do you have dentures, partials, etc.? ______________________
YES NO Do you have an emotional condition? If yes, please explain: ______________________

Female Patients Only:
When was your last period? ______________ Could you be pregnant? YES NO Are you post menopausal? YES NO
Have you had a Hysterectomy? YES NO Have you had a Tubal Ligation? YES NO

______________________ ______________________
Patient Signature Date