Reviewed by…	
RN signature	Date

MARIN SPECIALTY SURGERY CENTER

an affiliate of SCA

7. Pre-op Questionnaire pg 1

Patient Sticker on arrival

PRE OPERATIVE QUESTIONNAIRE page 1

Name: ________________________ ________________ _______ **Age:**_____ **Date:** ____ /____ /____

Last First Middle Initial

Date of Surgery: ____ /____ /____ Surgeon: ___________ Height: ____ft ____in Weight: _______lbs

Primary M.D.__________________ Cardiologist: ___________________ Other: ______________________

MEDICATIONS

Be specific, please read the bottle, spell the name of the medication correctly, list the dosage as indicated on the bottle, and don't forget to list when you take your medication during the day.

Include "blood thinning" meds, aspirin, and over-the-counter, weight loss, and/or herbal supplements.

Medication Name	Dosage	Time/s of day		Medication Name	Dosage	Times/s of day

SURGERIES

Procedure	Year

ALLERGIES

Medication / Allergen	Reaction
Latex Sensitivity? Yes☐ No☐	

In Case of an Emergency, Please Notify…

Name	
Relationship	
Telephone	
Who is driving you home from the surgery center?	
Name	
Telephone	

Anesthesia Questions	YES	NO
Have you or any one in your family ever had a reaction or complication from a general or local anesthetic?	☐	☐
Do you have fear of anesthesia?	☐	☐
Have you ever had an unsatisfactory experience with anesthesia?	☐	☐
History of post op nausea and vomiting?	☐	☐
Other		

Please note anything (health or otherwise) you wish that might help us take better care of you.

Reviewed by...

________________ __________
________________ __________
________________ __________
________________ __________
________________ __________

RN signature Date

MARIN SPECIALTY
SURGERY CENTER
an affiliate of SCA

7. Pre-op Questionnaire pg 2

Patient Name:

____

Sticker on arrival

PRE OPERATIVE QUESTIONNAIRE Page 2

GENERAL HEALTH

Do you have, or have you ever had any of the following. Please use space on pg 1 to explain.

Nervous System	YES	NO
Seizures &/or Epilepsy	☐	☐
Strokes	☐	☐
Black out spells	☐	☐
Paralysis or weakness	☐	☐
Equilibrium problems	☐	☐
Headaches	☐	☐
Other Neurological problems	☐	☐

Heart & Blood Vessels	YES	NO
High blood pressure	☐	☐
Heart Attack	☐	☐
Heart Failure	☐	☐
Do you take diuretics or "water pills"	☐	☐
Rheumatic fever	☐	☐
Heart Murmur / mitral valve prolapse	☐	☐
Chest / pain	☐	☐
Irregular Heart Beats	☐	☐
Phlebitis / Blood Clots	☐	☐
Pacemaker	☐	☐
Automatic Internal defibrillator	☐	☐
Bleeding problems	☐	☐

Personal	YES	NO
Do you drink Alcohol	☐	☐
# glasses/day______# glasses/wk______	☐	☐
History of alcohol or drug abuse	☐	☐
Clean and Sober for ___________	☐	☐
In rehab presently	☐	☐
Anything removable in your mouth	☐	☐
Do you wear glasses	☐	☐
Do you wear contacts	☐	☐
Women: Are you pregnant?	☐	☐
Last Menstrual Period _____________	☐	☐
Body Piercings remove all metal jewelry before surgery	☐	☐
Hard of Hearing (circle) Right, Left	☐	☐
Hearing Aide (circle) Right, Left	☐	☐
History of mental or emotional problems	☐	☐

Respiratory System	YES	NO
History of smoking? # yrs _____ when quit ____	☐	☐
Packs / day _______ cig / day ________	☐	☐
Nicotine? Other? _________________	☐	☐
Pneumonia or bronchitis	☐	☐
Asthma or wheezing	☐	☐
Tuberculosis	☐	☐
Shortness of Breath	☐	☐
Emphysema / COPD	☐	☐
Other lung problems	☐	☐

Gastro-Intestinal / Urinary / Abdomen	Yes	NO
Kidney disease	☐	☐
Ulcers	☐	☐
Hiatal hernia	☐	☐
Hepatitis	☐	☐
Jaundice	☐	☐
Gastric Reflux Disease / "Heart Burn"	☐	☐
Special bowel/bladder needs	☐	☐
Other abdominal problems	☐	☐
Diabetes	☐	☐
Last Blood Glucose date/time_____ /______	☐	☐
Benign Prostatic Hypertrophy	☐	☐

Skeletal / Other	YES	NO
Osteoporosis	☐	☐
History of Back or Neck surgery?	☐	☐
Backaches	☐	☐
Implanted Hardware	☐	☐
Arthritis	☐	☐
Total joint surgery	☐	☐
Immune Deficiency	☐	☐
Cortisone drugs taken w/in the past 2 yrs.	☐	☐
Antibiotics for dental procedures	☐	☐
Recent Cough, Cold, Flu, infections	☐	☐
Skin Problems, bruises, rashes... describe	☐	☐
Current outbreak of acne, herpes...describe	☐	☐
History of antibiotic Resistant infections?	☐	☐
History of cancer	☐	☐
Latex: Sensitivity or Allergy	☐	☐