MARIN SPECIALTY
SURGERY CENTER
an affiliate of SCA

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 Include "blood thinning" meds, aspirin, and over-the-counter, weight loss, and/or herbal supplements						
Medication Name	Dosage	Times/day		Medication Name	Dosage	Times/day

SURGERIES	
Procedure	Year

ALLERGIES	
Medication / Allergen	Reaction

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.

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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 our 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	☐	☐

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	☐	☐