

**Health Questionnaire**

Surgeon's Name \_\_\_\_\_

Surgery / Procedure Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Medical Doctor's Name: \_\_\_\_\_ Last Seen: \_\_\_\_\_

*Please answer the following questions to the best of your ability. Any other information you'd like to share regarding your health history or comments, please elaborate at the end of the questionnaire.*

**Do you have, or have you ever had, the following conditions, illnesses or symptoms?**

**PLEASE CIRCLE YOUR ANSWER?**

**Neurological:**

Stroke / Mini Strokes	Yes	No
Seizures	Yes	No
Migraines	Yes	No
Fainting	Yes	No
Depression	Yes	No
Multiple Sclerosis	Yes	No

**Respiratory:**

Asthma	Yes	No
Shortness of Breath	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No
Pneumonia	Yes	No
Chronic Cough	Yes	No
Sleep Apnea / CPAP machine	Yes	No
Do you smoke?	Yes	No
How Much? _____	PPD	
Recent Cold or Flu?	Yes	No

**Cardiac:**

High Blood Pressure	Yes	No
Heart Attack	Yes	No
Angina / Chest Pain	Yes	No
Palpitations / Irregular Heart Beat	Yes	No
Heart Murmur	Yes	No
Heart Bypass Surgery	Yes	No
Angioplasty	Yes	No
Pacemaker / Defibrillator	Yes	No
Congestive Heart Failure	Yes	No

**Urinary:**

Kidney Disease	Yes	No
Dialysis	Yes	No

**Endocrine:**

Diabetes	Yes	No
Hypothyroidism	Yes	No
Hyperthyroidism	Yes	No

**Liver / Gastrointestinal:**

Hepatitis	Yes	No
Jaundice	Yes	No
Liver Disease	Yes	No
Cirrhosis	Yes	No
Hiatal Hernia	Yes	No
Heartburn	Yes	No
Acid Reflux	Yes	No
Do you drink alcohol?	Yes	No
How Much? _____		
Do you use recreational drugs?	Yes	No
How Often? _____		

**Hematologic / Oncological:**

Clotting Disorders	Yes	No
Anemia	Yes	No
Blood Clots in legs or lungs	Yes	No
History of Cancer? Where? _____		
Radiation Therapy	Yes	No
Chemotherapy	Yes	No

**Allergies:**

Please list medications, latex and environmental allergies. What type of reaction did you have?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list prior surgeries:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had an anesthetic complication or is there a family history of anesthesia complications? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Pediatric Patients ONLY:**

Was child born prematurely?	Yes	No
How many weeks premature? _____		
Any problems noted at birth? _____		

\_\_\_\_\_

Completed by: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**PLEASE NOTIFY THE NAUGATUCK VALLEY SURGICAL CENTER IF THERE IS ANY CHANGE IN YOUR HEALTH STATUS PRIOR TO SURGERY.**