

# ACADEMY ORTHOPEDICS AMBULATORY SURGERY CENTER

## Pre-Surgical Questionnaire

**For Clinical Staff Use:**

Medical Clearance required: YES NO  
Medical Clearance letter to pt: YES NO

**\*Please address each question**

Patient name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

Name of contact \_\_\_\_\_ Phone where contact can be reached \_\_\_\_\_

**PRESENT ILLNESS:**

Your current condition (*nurse to complete*): \_\_\_\_\_

How long has this condition been present: \_\_\_\_\_ If female – any chance you could be pregnant: YES NO

Drug Allergies (*circle*): Penicillin Sulfa Iodine Codeine Morphine Latex Other \_\_\_\_\_

What type of reaction to allergy: \_\_\_\_\_

Daily Medications: \_\_\_\_\_

Do you take any OTC meds, vitamins, herbal supplements: \_\_\_\_\_

<b>PAST MEDICAL HISTORY: Do you / have you had the following: (please circle YES NO, and if YES please explain</b>									
<b>EYES:</b> Contacts YES NO Cataracts YES NO	<b>CARDIAC / HEART:</b> High Blood Pressure YES NO Heart Attack YES NO Pacemaker YES NO Bypass Surgery YES NO Chest Pain YES NO Heart Failure YES NO Heart Murmur YES NO Irregular Beats YES NO Abnormal EKG YES NO M. Valve Prolapse YES NO High Cholesterol YES NO	<b>LUNGS:</b> Asthma YES NO Chronic Bronchitis YES NO Emphysema YES NO Tuberculosis YES NO COPD YES NO Sleep Apnea YES NO	<b>DIGESTIVE:</b> Heart burn/reflux YES NO Freq. indigestion YES NO Hiatal hernia YES NO						
<b>EARS:</b> Surgeries YES NO	<b>Exercise cause:</b> Chest pain YES NO Short of Breath YES NO	<b>BLOOD ABNORMALITIES:</b> Bleeding trouble YES NO Clotting trouble YES NO HIV YES NO Anemia YES NO Sickle cell YES NO	<b>LIVER:</b> Hepatitis YES NO Elevated enzymes YES NO						
<b>NOSE:</b> Fractures YES NO	<b>FACE:</b> Fractures YES NO	<b>BACK:</b> Spine Fracture YES NO	<b>SEIZURES</b> YES NO						
<b>FACE:</b> Fractures YES NO	<b>DENTURES:</b> YES NO	<b>STROKE</b> YES NO TIA's YES NO (mini stroke)							
<b>THYROID DISEASE</b> YES NO	<b>DIABETES</b> YES NO								
<b>KIDNEY Disease:</b> YES NO									

Description of "YES" above \_\_\_\_\_ Other conditions \_\_\_\_\_

**PAST SURGICAL HISTORY:** \_\_\_\_\_

**\*\*Have you or a family member ever had problems with general anesthesia:** YES NO

If yes, please explain: \_\_\_\_\_

**FAMILY HISTORY:** do you or your parents have any medical problems (High Blood Pressure, Diabetes, Heart problems...)

YES NO If yes please explain \_\_\_\_\_

**SOCIAL HISTORY:**

Do you use tobacco YES NO If yes how much \_\_\_\_\_ If no did you smoke in the past YES - Years quit \_\_\_\_ NO

Do you drink alcohol YES NO If yes how much \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_