ESSEX SPECIALIZED SURGICAL INSTITUTE
PRE-OPERATIVE HEALTH QUESTIONNAIRE

PATIENT NAME_____ DATE_____ASC#_____

NAME OF YOUR MEDICAL DOCTOR_____ PHONE_____

HAVE YOU EVER HAD?:

Y___N___ HEART CONDITION: ☐ High Blood Pressure ☐ Angina ☐ Bypass ☐ Surgery if yes _____

Y___N___SIGNIFICANT **FAMILY HISTORY** OF CARDIO VASCULAR PROBLEMS INCLUDING STROKE. IF YES, WHO _____

Y___N___LUNG SURGERY If yes, which lung ☐ Left ☐ Right

Y___N___ASTHMA / BREATHING PROBLEMS /TUBERCULOSIS _____

Y___N___DIABETES (HIGH SUGAR) ☐ Insulin Dependent ☐ Non-Insulin Dependent (NIDDM)

Y___N___STROKE / SEIZURES / CONVULSIONS

Y___N___ (CJD) CREUTZFELDT-JAKOB DISEASE

Y___N___BLEEDING PROBLEMS/ JAUNDICE/ HEPATITIS/ LIVER PROBLEMS

Y___N___ (HIV) HUMAN IMMUNODEFICEINCY VIRUS /AUTOIMMUNE DISEASES_____

Y___N___KIDNEY DISEASE ☐ Dialysis ☐ Shunt, location_____

Y___N___BREAST SURGERY ☐ Left ☐ Right ☐ Both

Y___N___PREVIOUS SURGERY(S) If yes explain_____

Y___N___A BAD REACTION TO LOCAL OR GENERAL ANESTHESIA

Y___N___ALLERGIES OR REACTIONS TO DRUGS/SHELLFISH/IVP DYE/LATEX - If yes please list: _____

Y___N___TAKE PRESCRIPTION MEDICATIONS PLEASE LIST

NAME	DOSAGE

Y___N___ ARE YOU PREGNANT? LAST MENSTRUAL PERIOD DATE: _____

DO YOU HAVE ANY PAIN? Y___ N___ IF YES PLEASE RATE ON THE SCALE (0=NONE 10=SEVERE)

0 1 2 3 4 5 6 7 8 9 10 >10 IF SO, WHERE? _____

WHAT RELIEVES THE PAIN? _____

DO YOU:

Y___N___HAVE A PACEMAKER/ IMPLANTABLE DEFIBRILLATOR /CARDIOVERTER

Y___N___WEAR A HEARING AID

Y___N___WEAR CONTACT LENSES

Y___N___HAVE DENTURES, CAPS, BRIDGES - PLASE CIRCLE

Y___N___SMOKE IF SO HOW MUCH PER DAY

Y___N___DRINK ALCOHOL? IF SO, HOW MUCH PER DAY _____

Y___N___DISABILITY/PROSTHESIS

Y___N___USE WHEELCHAIR, CANE, WALKER - PLEASE CIRCLE

TRANSLATION: ____BY FAMILY MEMBER ____BY ESSI STAFF ____SAME AS PREVIOUS

EMERGENCY CONTACT: NAME _____ PHONE # _____

_____

PATIENT'S SIGNATURE REVIEWED BY (RN/LPN SIGNATURE) DATE