Willoughby Surgery Center (440) 585-2750

Patient Questionnaire - Your careful completion of this form will help us provide you with our highest quality of care for your procedure.

Name	Age	Date of Birth	Height	Weight
		___/___/___	___ ft. ___ in.	___ Lbs.

Do You have Any Allergies to Drugs, Latex, Iodine. Adhesives, Food, or others ? (circle) No Yes If Yes, Please List Them Below.

Allergy To:	Reaction :

Allergy To:	Reaction :

Do You Take Any Medications or Herbal Supplements ? (circle) No Yes. If Yes, Please List Them Below.

Medication Name:	Dose (mg)	# / day

Medication Name:	Dose (mg)	# / day

Your Primary Care Physician:_____ Phone #:(____)____-_____ fax #:_____-_____

Does He/She Need to Clear You for Surgery ? (circle) No Yes

Have You Ever Had Any Surgeries ? (circle) No Yes If Yes, Please List Below.

Type of Surgery	Year

Type of Surgery	Year

Other Than For Surgery, Have You Been Hospitalized For Anything Else ? (circle) No Yes If Yes, Please List Below.

Reason For Hospitalization (Diagnosis)	Year

Reason For Hospitalization (Diagnosis)	Year

VERY IMPORTANT !!! **I understand that I am not to eat or drink as instructed prior to the Day of Surgery unless instructed otherwise by Willoughby Surgery Center Staff. I also understand that I must have a responsible adult accompany me home after discharge from the Willoughby Surgery Center.**

Date Completed _____ Signature : _____ **Go To Back Side**

--------- Office Use Below ----------

New Changes	Date	Changes	Signature
Yes No			
Yes No			
Yes No			
Yes No			
Yes No			
Yes No			

Circle Answer	General Questions
Yes No	Have you or anyone in your family ever had a serious problem with Anesthesia ? If Yes, please describe: _____
Yes No	Recent Cold or Flu ? Describe Symptoms : _____
Yes No	Do you Smoke ? If so, how many packs per day ? _____ For how many years ? _____
Yes No	Do you use any Recreational Drugs ? (Cocaine, Marijuana, etc.) Please list them : _____
Yes No	Do you drink any Alcohol ? How many drinks per day ? _____ For how many years ? _____
Yes No	Any loose Teeth , Caps, Partial Bridges ? Describe : _____
Yes No	Any Lung / Pulmonary disease ? (circle) Asthma , Bronchitis , Emphysema / COPD , Home Oxygen, Sleep Apnea
	If Yes. How many days ago did you have a wheezing episode ? _____ Are you now the best you can be? Yes No
Yes No	Shortness of Breath Upon Climbing Up Stairs ? How many flights before you have to stop to rest ? _____
Yes No	Ever have a Heart Attack ? If so, when ? _____
Yes No	Have you been diagnosed with CHF (congestive heart failure) ? If so, how have you been lately ? _____
Yes No	Ever have a Stress Test or Cardiac Catheterization ? If so, circle it and write dates and results . _____
Yes No	Diagnosed with Hypertension ? If so, is your doctor pleased with your blood pressure control ? Yes No .
Yes No	Ever had a TIA or Stroke ? If so, what deficits do you have now ? _____
Yes No	Ever had Epilepsy or Seizures ? If so, when was your last seizure ? _____
Yes No	Ever have any Blood Diseases, Anemia, Sickle Cell etc.? Describe : _____
Yes No	Excessive Bleeding or Bruising ? Describe : _____
Yes No	Ever diagnosed with Diabetes ? Any Complications ? Please Describe : _____
Yes No	Any Thyroid problems ? Describe : _____
Yes No	Any Liver problems ? Describe : _____
Yes No	Chronic Headaches, Neck or Back Pain ? Describe : _____
Yes No	Weakness / Numbness in a Limb ? Describe : _____
Yes No	Ever have Reflux or Hiatal Hernia ? How has it been lately ? _____
Yes No	Ever diagnosed with Arthritis or Rheumatological Disease ? Describe : _____
Yes No	Ever Diagnosed with Cancer ? Describe : _____
Yes No	FEMALE PATIENTS - Could You Be Pregnant ? When was you last normal menstrual period ? _____
Yes No	Any other significant Diseases or Information ? Describe : _____

Date Completed _____ Signature : _____

-------- Office Use Below ----------

New Changes	Date	Changes	Signature
Yes No	_____	_____	_____
Yes No	_____	_____	_____
Yes No	_____	_____	_____
Yes No	_____	_____	_____
Yes No	_____	_____	_____
Yes No	_____	_____	_____