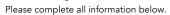
Pre-Operation Questionnaire





Patient Information					
Patient Name:	Date of Birth:				
Doctor's Name:	Today's Date:				
Preferred Pharmacy:					
Pharmacy Location:					
What body part(s) is this visit regarding	g?				
SHOULDER: Left Right	ELBOW: Left Right	WRIST: Left Right			
HAND: Left Right	HIP: Left Right	KNEE: Left Right			
ANKLE: Left Right	FOOT: Left Right				
OTHER:					
Please answer all of the following:					
1. Since your last visit, how are you feeling	ng?	☐ Better ☐ Worse ☐ Same			
2. On a scale of 0 to 10 (10 is worst), wha	at is the severity of your pain? (circle one): 0	1 2 3 4 5 6 7 8 9 10			
3. Do you have, or have you had, any of	the following conditions:				
a. Heart issues (e.g. high cho	lesterol, high blood pressure)	Yes No			
b. Do you have a cardiologist	t? Yes No If "Yes," physician's	name:			
c. History of blood clot(s)		Yes No			
d. Breathing problems (e.g. a	isthma, sleep apnea, COPD)	Yes No			
e. Do you use a CPAP or BiPA	AP machine?	Yes No			
f. Hepatitis or liver trouble		Yes No			
g. Kidney problems		Yes No			
h. Do you have a nephrologis	st? Yes No If "Yes," physician's	name:			
i. Epilepsy, seizures, or fits		Yes No			
j. Glaucoma		Yes No			
k. Bleeding disorders (e.g. Si	Bleeding disorders (e.g. Sickle cell, hemophilia)				
I. Gastrointestinal problems	(e.g. acid reflux, hernia, ulcer, heartburn)	Yes No			
m. Diabetes	Yes No If "Yes," when was la	st AIC:			
4. Have you had any blood drawn or an EKG in the last 60 days?					
5. Do you have a history of anesthesia p	roblems?	Yes No			
6. Do you have a family history of anesth	nesia problems?	Yes No			
7. Any chance of pregnancy? (women or	nly)	Yes No			
8. Do you smoke (including marijuana)?	Yes No If "Yes," how	often?			
9. Do you drink alcohol?	Yes No If "Yes," how	much?			
List all previous surgeries:					
Previous Surgery		Date			
Do you have any metal in your body?	Yes No If "Yes," list	where:			

Please complete the reverse side of this form.

Check if you have allergies to: Allergy	Latex Tape	lodine Reaction	
List all medications including Name of Medication	over-the-counter (OTC) medications and supplements Dosage	s you are taking: Frequency
Patient Signature: MD/PA-C Signature: For Office Use Only Blood Pressure:	Pulse:	Date:	