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PATIENT PRE-ADMISSION QUESTIONNAIRE

Name: _____ D.O.B. ____/____/____ Date of Procedure: ____/____/____
 Phone #: _____ Height: _____ Weight: _____

Proposed Procedure: _____
 Surgeon: _____
 Family Doctor: _____

- ◆ Do you have any allergies or sensitivities to drugs, dyes, any kind of tape, latex products, foods, etc? YES NO
 If YES, to what? _____
 What type of reaction?:
 RASH HIVES NAUSEA SWELLING TROUBLE BREATHING
- ◆ Do you take any medicines every day? (Including Aspirin, Birth Control Pills, Maalox.) . *If yes, Please list below and bring to the hospital:* YES NO

- ◆ Do you take any herbal products, diet pills, over-the-counter products?..... YES NO
 If YES, what? _____

NOTE: If you currently are taking herbal / diet remedies, we recommend they be stopped 2 weeks prior to your procedure date.

- ◆ Could you be pregnant? YES NO
- ◆ Have you ever smoked cigarettes? YES NO
 a. How many a day? _____ b. For how long? _____ c. Do you smoke now? _____
- ◆ Do you drink alcohol? YES NO
 a. How often? _____ b. What kind? _____ c. How much? _____
- ◆ Have you ever had an operation before? YES NO
 a. If YES, what kind and when? _____
 b. Do you remember what type of anesthesia you had? YES NO
 General Spinal Epidural Local
 c. Did you ever have a problem with anesthesia? YES NO
 If YES, what? _____
 d. Has anyone in your family ever had a problem with anesthesia? YES NO
 If YES, what? _____

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- ◆ Have you ever had a : heart attack? YES NO
 heart condition? YES NO
 - Have you ever experienced: chest pain (angina)? YES NO
 high blood pressure? YES NO
 shortness of breath? YES NO
 pressure in your chest? YES NO
 palpitations or irregular heart beat? YES NO
 abnormal electrocardiogram? YES NO



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- ◆ Do you snore? YES NO
- Do you suspect or have you been diagnosed with Sleep Apnea?..... YES NO
- Have you had sleep studies performed? YES NO
- Do you wake at night short of breath? YES NO
- Do you have difficulty breathing while climbing stairs? YES NO
- Have your lungs ever filled with fluid? YES NO
- Can you lie flat in bed without getting short of breath? YES NO
- Has anyone ever told you that you have a heart murmur or that you need antibiotics before you have dental work? YES NO
- ◆ Have you seen a cardiologist within the last year? YES NO
- If **YES**, inform him / her of your impending surgery and obtain a note regarding your condition and copies of cardiac testing, including stress and echo tests.
- Name: _____ Phone: _____
- Address: _____

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- ◆ Do you have a history of asthma, pneumonia, bronchitis, wheezing, or tuberculosis? YES NO
 - Have you ever had an abnormal chest X-ray? YES NO
 - Do you cough daily? YES NO
 - Have you had a recent cough or cold? YES NO
 - ◆ Have you seen a lung specialist within the last year? YES NO
 - If **YES**, inform him / her of your impending surgery and obtain a note regarding your
 - Name: _____ Phone: _____
 - Address: _____

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- ◆ Do you have any problems with your liver? YES NO
 - Have you ever had hepatitis or jaundice? YES NO
 - Do you have ulcers, gastritis, hiatal hernia, heartburn, or regurgitation? YES NO
 - Do you have diabetes or trouble with your blood sugar? YES NO
 - Do you have trouble with your thyroid? YES NO
 - Have you ever had kidney trouble or kidney stones? YES NO
 - Have you ever had a seizure, stroke, dizziness, fainting spells, or a weakness in your arms or legs? YES NO
 - Do you have anemia (low blood), bleeding problems, frequent nose bleeds, blood clots, or bruise easily? YES NO
 - Do you or a member of your family have sickle cell anemia? YES NO
 - Do you have cancer or have you received radiation or chemotherapy? YES NO
 - Have you ever had a blood transfusion? YES NO

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- ◆ Any medical conditions we did not ask you about?..... YES NO
 - If Yes, what?

Patient Signature: _____ Date: ____/____/____

NOTE TO PHYSICIAN'S OFFICE

Please ensure this form is forwarded to the Hartford Hospital Pre-Admission Testing Center.

Prior to this date: _____

FAX: 545-4335 or Phone: 545-2334