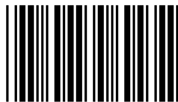
Hartford Hospital
A Hartford HealthCare Partner
West Hartford Surgery Center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PATIENT PRE-ADMISSION QUESTIONNAIRE

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? _________________________

- Have you ever had a : / Have you ever experienced:

heart attack?	❒ **YES**	❒ **NO**
heart condition?	❒ **YES**	❒ **NO**
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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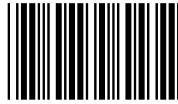
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PATIENT PRE-ADMISSION QUESTIONNAIRE

- ♦ 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: ____

- ♦ 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: ________________________

- ♦ 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

- ♦ Any medical conditions we did not ask you about? ❒ YES ❒ NO

If Yes, what?

Patient Signature: ________________________ Date: _______ Time: _______

NOTE TO PHYSICIAN'S OFFICE

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

Prior to this date: __________

FAX:860- 231-6185 or Phone:860-586-8655