Saint Alphonsus
A Member of Trinity Health

Pre-Procedure Health Questionnaire

Prior to your surgery or procedure a nurse will call you so please be prepared to answer these questions. This information is very important for the Anesthesiologist and Surgeon.

Name: _____ **Date of Birth** _____/_____/_____

Phone: (_____) _____-_____

Name of person who will drive you home after your procedure:

_____

Relationship: _____

Phone (_____) _____-_____

Name of person who will assist you at home after your procedure (if different than individual listed to the left):

_____

Relationship: _____

Phone (_____) _____-_____

1. Do you have Advance Directives or a Living Will?
☐ Yes ☐ No

If yes, does Saint Alphonsus have a copy of your Advance Directives or Living Will? ☐ Yes ☐ No

2. Have you or a family member ever had a reaction to anesthesia? ☐ Yes ☐ No

3. Have you ever had a blood transfusion of someone else's blood? ☐ Yes ☐ No

If yes, did you have a reaction? ☐ Yes ☐ No

4. Do you have any religious, cultural, or personal reasons to refuse blood or blood products in a medical emergency?

☐ No It is OKAY to give me blood products in a medical emergency

☐ Yes I refuse blood products because:
_____

5. In the last 3 months, have you traveled outside the US? ☐ Yes ☐ No

6. Have you had the COVID-19 vaccination?
☐ Yes ☐ No

7. If you're going to have a colonoscopy, please list the date you had one last: _____

8. Do you have any implanted devices? ☐ Yes ☐ No
If yes please list: _____
_____

9. Do you use any assistive devices like a cane or walker?
☐ Yes ☐ No
If yes please list:_____

10. Do you wear dentures or have loose teeth?
☐ Yes ☐ No

Please truthfully answer the questions below. They will not prohibit you from having surgery but will help Anesthesia provide the best care possible.

11. Have you ever habitually used tobacco products?
☐ Yes ☐ No

If Yes, which of these? ☐ Cigarettes ☐ Pipe ☐ Chew
How much per day? _____
How many years? _____ Quit date:_____

12. Are you exposed to a lot of secondhand smoke?
☐ Yes ☐ No

13. In the last 5 years have you used recreational drugs?
☐ Yes ☐ No

If yes type: _____

14. Have you used marijuana in any form?
If yes, explain: _____

15. Have you ever abused prescription drugs?
☐ Yes ☐ No
If yes type: _____

16. Do you drink alcohol? ☐ Yes ☐ No
If yes, how much and how often? _____
_____

Pre-Procedure Health Questionnaire

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If you already have your medical history, allergies, and medications written down you do not need to fill out the section below. Please have the information ready for the nurse.

Medical History:

Please check the boxes of conditions you've been diagnosed with:

- ☐ Aids
- ☐ Anemia or Bleeding Conditions
- ☐ Asthma
- ☐ Diabetes
- ☐ Gerd / Acid Reflux
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Malignant Hyperthermia
- ☐ Motion Sickness
- ☐ MRSA
- ☐ Muscle Disease
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stroke
- ☐ Tuberculosis
- ☐ VRE

Please list any other medical conditions:

_____

_____

_____

Please list any surgeries you've had:

_____

_____

_____

Do you currently have a cold? ☐ Yes ☐ No

Do you have any food allergies or are you allergic to any medication? ☐ Yes ☐ No

If yes, please provide details:

_____

_____

Medications:

Please list ALL medications you are taking including over-the-counter, herbs, vitamins and other supplements:

Name:	
Dose:	How often:

Name:	
Dose:	How often:

Name:	
Dose:	How often:

Name:	
Dose:	How often: