

Patient Questionnaire/Assessment Form

Patient's Name: _____ **Date of Birth:** _____

Have you had any problems with blood pressure, heart, or circulation (including any history of chest pain assoc. with use of nitroglycerin) **Yes No**

Have you had any lung disease, asthma, recent cough, cold or sore throat? **Yes No**

Have you had any seizures, strokes, convulsions, blackouts, fainting spells, Or headaches? **Yes No**

Have you had any disease of the stomach/intestine, liver, jaundice, hepatitis or a reaction to a transfusion **Yes No**

Do you have a bleeding disorder or bleeding tendency? **Yes No**

Do you have diabetes or thyroid disease? (please circle which applies) **Yes No**

Do you have other health problem(s) not mentioned above?(If yes, list briefly) **Yes No**

Have you ever had an operation? If so please list with year of surgery **Yes No**

Have you or any blood relative ever had a reaction to local or general anesthesia (excludes nausea and vomiting) **Yes No**

Do you have more than 2 alcoholic drinks per day? **Yes No**

Do you or have you ever smoked? If yes, how much _____ **Yes No**
If you have stopped when _____

Do you have any allergies to specific medications? Please list including reaction **Yes No**

Do you have an allergy to latex or tape? (Circle which applies) **Yes No**

List your medications (Include prescription, over-the counter, vitamins and herbal supplement).

Weight _____ Height _____

Females: Is there a possibility that you may be pregnant? **Yes No**

Signature of person completing form: _____ Date: _____

Reviewed by Physician: _____ Date: _____