UCAS UNIVERSITY CENTER FOR AMBULATORY SURGERY

Patient Health Questionnaire

Please take a moment to carefully answer the following questions to the best of your knowledge. Place a check mark in the Yes/No column or write your response on the appropriate line. This information will be reviewed by your anesthesiologist prior to surgery and help in preparing and conducting a safe anesthetic for you. Thank you.

Name: _____ Age:_____ Height:_____ Weight:_____

Telephone #:_____ Medical Doctor: _____

Do you take Aspirin or any blood thinners? € Yes € No Do you have any metal implants: € Yes € No

Allergies to medications, latex, or food: _____

Prior surgeries and year: _____

Have you or any immediate family members had problems with anesthesia in the past? € Yes € No

	Yes	No		Yes	No
Do you smoke? If yes, how many packs per day? _____			Have you ever been diagnosed with sleep apnea?		
Do you drink alcohol? If yes, how much? _____			If yes, do you use a CPAP machine at home?		
Do you take birth control pills?			Have you had a recent sore throat or chest cold?		
Could you be pregnant?			Do you have asthma, bronchitis, emphysema, or pneumonia?		
Date of last menstrual period _____			Do you have difficulty opening your mouth?		
Do you have any loose teeth, dentures or caps?			Do you have stomach problems? (ulcers or heartburn?)		
Do you wear contact lenses?			Do you have a hiatal hernia?		
Do you have a past history of drug abuse?			Have you ever been treated for anemia?		
History of stroke or temporary black out?			Do you have Sickle Cell anemia or a trait?		
Have you been treated for TB?			Do you bruise or bleed easily?		
Any unexplained weight loss in the past 6 months?			Have you ever had a blood transfusion?		
Do you have high blood pressure?			Have you ever had kidney failure, stones, or infection?		
Do you get chest pains (angina)?			Do you have thyroid disease?		
Have you had a heart attack or congestive heart failure?			Do you have liver disease (cirrhosis or hepatitis)?		
Do you get palpitations?			Do you have diabetes?		
Do you have a heart murmur?			Do you have arthritis of your jaw, neck, or back?		
Do you have a pacemaker or AICD/defibrillator?			Have you fallen within the last 60 days?		
Have you ever had rheumatic fever?			Do you have a history of blood clots?		
Do you bruise or bleed easily?			Do your legs (calves) get cramps when you walk a short distance?		

Patient Signature; _____ Date: _____