

**MCKENZIE SURGERY CENTER
PRE-ADMISSION QUESTIONNAIRE**

Name of Patient: _____

Age: _____ Date of Birth: _____

Doctor: _____

The following information is very important to your health and will help in determining our plan of care to meet your needs. Please take the time to fully and accurately fill out this form.

PLEASE BRING THIS FORM AND THE CURRENT MEDICATION SHEET WITH YOU TO THE CENTER

MEDICAL HISTORY

Height _____ Weight _____

	YES	NO
MEDICATIONS: Are you currently taking any prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly take any over-the-counter medications, herbal medicines or vitamins ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly take ASPIRIN or aspirin containing medications?	<input type="checkbox"/>	<input type="checkbox"/>

Please list your medications on the enclosed Current Medication/Allergy List Sheet (Pink sheet)

ALLERGIES: Do you have any allergies to medications?	<input type="checkbox"/>	<input type="checkbox"/>
Other substances?	<input type="checkbox"/>	<input type="checkbox"/>

Please list your allergies on the enclosed Current Medication/Allergy List Sheet (Pink Sheet)

	YES	NO	
ANESTHESIA: Have you ever had general anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	Please list or explain any YES answers
Have you or any family members ever had a bad reaction to anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	
Has anyone in your family experienced Malignant Hyperthermia during anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	
SURGERY: Have you had any previous surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever suffered any serious problems with any of your surgeries or recoveries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
HOSPITALIZED: Have you been hospitalized for any serious illnesses or injuries not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	_____
SPECIAL NEEDS: Any special needs we should know about?	<input type="checkbox"/>	<input type="checkbox"/>	_____
APPLIANCES: Do you have any loose teeth, dentures, crowns, permanent retainers, contacts, prostheses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
PREGNANCY: Is there any possibility that you are pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, have you notified your surgeon?	<input type="checkbox"/>	<input type="checkbox"/>	_____
DRUG USE: Have you in the past or are you presently using recreational type drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been a patient at MSC before?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Date: _____ Other Name _____			_____
Do you have any current illnesses or injuries apart from the surgical procedure?	<input type="checkbox"/>	<input type="checkbox"/>	_____

PLEASE COMPLETE REVERSE SIDE

GENERAL HEALTH

Do you have, or have you ever had any of the following?

	YES	NO		YES	NO
NERVOUS SYSTEM			LUNGS		
Seizures and/or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia or bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Black -out spells	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis or weakness	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Equilibrium problems	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>
Other neurological problems	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Snore: do you, or has someone said you do	<input type="checkbox"/>	<input type="checkbox"/>
HEART AND BLOOD			Other lung problems	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? How many per day _____		
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	ABDOMEN		
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur/mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis/Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Other abdominal problems	<input type="checkbox"/>	<input type="checkbox"/>
Any bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Any special bowel/bladder needs?	<input type="checkbox"/>	<input type="checkbox"/>
OTHER			Gastric reflux disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	OTHER		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Drink Alcohol? How much per week _____		
Orthopedic limitations	<input type="checkbox"/>	<input type="checkbox"/>	Growth or developmental delays	<input type="checkbox"/>	<input type="checkbox"/>
MRSA: drug resistant staph infection	<input type="checkbox"/>	<input type="checkbox"/>	Diagnosed syndromes or diseases	<input type="checkbox"/>	<input type="checkbox"/>
Comments/Explanations:					

SURGICAL PREPARATION

	Yes	No	EXPLANATION
Has your physician ordered any blood work?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had this done? If yes, where and when?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has your physician ordered x-rays?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had this done? If yes, where and when?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has your physician ordered an EKG?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had this done? If yes, where and when?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you made arrangements for a responsible adult to be with you at home for 24 hours after your surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Who is that person? _____			
Will that same person drive you from the center?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If "no", who will it be _____			

The information provided is accurate to the best of my knowledge.

Signature _____ Date _____

Thank you for completing this questionnaire. All information will be kept in strict confidence