Physician: Please fax to Center prior to surgery for review (212-434-2844)

FAX TO 212-434-2844

SurgiCare of Manhattan Department of Anesthesia

Patient Health Questionnaire

Please take a moment to carefully answer the following questions. 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. SurgiCare of Manhattan.

Name:_____ **A**ge:_____ Ht:_____ Wt :_____ Telephone #_____

List of medications _____

_____

_____

Do you take Aspirin? [ ] YES [ ]NO Medical Doctor: _____

Allergies to medications or foods? (include eggs/ soybean, latex rubber or condoms)_____

Prior Surgeries and year _____

Have you had any problems with anesthesia in the past? _____

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

Please sign when you have completed this form to the best of your knowledge and are satisfied that you understand the questions.

Patient Signature_____ Date: _____

FAX T0: 212-434-2844