PLEASE BRING THIS COMPLETED FORM WITH YOU ON THE DAY OF SURGERY

PRE-OPERATIVE PATIENT QUESTIONNAIRE

PRINT PATIENT NAME _____ **DATE OF SURGERY** _____

NAME OF YOUR REGULAR FAMILY DOCTOR: _____ OR ☐ I DO NOT HAVE A REGULAR FAMLY DOCTOR

DATE OF INJURY _____ WHERE INJURY OCCURRED/HOW _____

HEIGHT:_____ **WEIGHT:**_____

	YES	NO
1. When did you last have anything to eat or drink? _____		
2. Have you ever been a patient at The Orthopedic Surgery Center of Orange County? When? _____		
3. **Are you allergic to anything; including medications and/or materials? What:** _____		
4. Have you had any problems with blood pressure, previous heart attack, palpitations, angina or heart Disease such as mitral valve disease? If yes, What? _____		
5. Do you wake at night with indigestion, or have a known history of hiatal hernia or ulcer? _____		
6. Have you had an EKG in the past? Where? When? _____		
7. Do you have a pacemaker, defibrillator, artificial joints or prostheses? If yes, what? _____		
8. Do you have any other medical conditions? If yes, what? _____		
9. Have you had any seizures, migraine headaches, fainting spells, or stroke? _____		
10. Have you had hepatitis, liver disease or blood transfusion reactions? _____		
11. **Do you have diabetes, hypoglycemia or thyroid problems?**_____		
12. Do you have kidney problems? _____		
13. Do you have any physical disabilities, back or neck pain, limited neck motion, arthritis or bursitis? _____		
14. Within the last year, have you had cortisone or steroids? _____		
16. (Female patients of child-bearing age) Are you pregnant at this time? (Last menstrual period)_____		
17. Have you had a cold, sore throat or flu within last two weeks? _____		
18. Within the last 2 weeks, have you been exposed to any contagious disease? What? _____		
19. Have you taken any additional medications (including recreational drugs) in the last 24 hours? What? _____		
20. Do you get motion sick easily?_____		
21. Do you have any loose teeth, dentures, permanent or removable bridges, front capped teeth? _____		
22. Have you had any breathing problems, asthma, chronic bronchitis, emphysema? _____		
23. Do you smoke or have you smoked in the past? _____		
24. Do you snore heavily or have a history of sleep apnea? _____		
25. Have you or a blood relative ever had an anesthesia problem? _____		
24. Have you executed an Advance Directive for Medical Care? ☐yes ☐no If yes please bring on day of surgery.		

Medications, including herbals, taken on a routine basis at home:

Name	Dosage	Frequency	Last Dose	Reason for Use
1.				
2.				
3.				
4.				
5.				
6.				

Circle pain medications you have **EVER** taken:
Indicate any adverse reaction

TYLENOL_____

CODEINE_____

VICODIN_____

PERCODAN_____

ASPIRIN_____

Previous Surgeries: (List most recent first)	Year	Type of Anesthesia (General, Epidural, Spinal, Local)	Complications (Fever, nausea, vomiting, low BP)
1.			
2.			
3.			
4.			

REVIEWED BY: R.N.	DATE:	**PATIENT SIGNATURE**	**DATE:**

ORTHOPEDIC SURGERY CENTER

OF ORANGE COUNTY