

PREOPERATIVE PATIENT QUESTIONNAIRE

Hole 1/4 1 3/8 c-to-c

Name _____

Height _____ Weight _____ Age _____ Sex M / F

Home # _____ Alternate# _____

Name of person taking you home after your procedure _____

List all Allergies	Type of Reaction	Year

Please attach a list of medications
(include name, dose, frequency)

List all Previous surgeries, heart catheterizations, procedures

Have you or any of your family had any problems with an anesthetic YES NO
If yes, please explain _____

Are you an organ donor? Yes No
Do you have a living will/advanced directives? Yes No
Are you in pain today? Yes No Location: _____

Do you smoke? YES NO How much? _____
Years Smoking _____

Dentures Yes No
Caps/Crowns/Bonding/Implants/Veneers Yes No
Braces/Retainers Yes No
Loose teeth Yes No
Missing teeth Yes No
Chipped teeth Yes No
Contact Lenses Yes No
Glasses Yes No
Hearing Aid Yes No

Pipe? _____ Cigars? _____ Chew Tobacco? _____
Did you ever smoke? YES NO How much? _____
Date quit _____ # Years Smoked _____

Females only: Possibility of pregnancy? Yes No
First day of last menstrual period _____ Are you Menopausal?
Yes No
How long _____
Number of pregnancies _____ Number of births _____

Do you drink alcohol? YES NO Quantity _____
Recovering alcoholic? YES NO
Current Recreational drug use? YES NO Explain _____
Former drug abuse? YES NO Explain _____

