Richfield Medical Group Pre-Op Questionnaire

What type of surgery are you having?_____
Who is your surgeon?_____
What is the reason for surgery?_____
Date of your surgery _____
Hospital/Surgery Center Location_____
Fax Number for hospital/surgery center_____
Do you have a Healthcare Directive or Living Will?_____
Please answer each question by making an "X" in the appropriate box. Thank You!

	Yes	No	
1.	☐	☐	Do you have a history of heart attack, stroke, stent, bypass or surgery on an artery in the head, neck, heart or legs? Circle which one
2.	☐	☐	Do you ever have any pain or discomfort in your chest?
3.	☐	☐	Do you have a history of heart failure? If yes, when_____
4.	☐	☐	Are you troubled by shortness of breath when: walking on the level, up a slight hill or at night?
5.	☐	☐	Do currently have a cold, bronchitis or other respiratory infection?
6.	☐	☐	Do you have a cough, shortness of breath or wheezing?
7.	☐	☐	Do you sometimes get pains in the calves of your legs when you walk?
8.	☐	☐	Do you or anyone in your family have previous history of blood clots?
9.	☐	☐	Do you or anyone in your family have a serious bleeding problem such as prolonged bleeding following surgeries or cuts?
10.	☐	☐	Have you ever had problems with anemia or been told to take iron pills?
11.	☐	☐	Have you had any abnormal blood loss such as black, tarry or bloody stools, or abnormal vaginal bleeding?
12.	☐	☐	Have you ever had a blood transfusion? If yes, when_____
13.	☐	☐	Have you or any of your relatives ever had problems with anesthesia?
14.	☐	☐	Do you have sleep apnea, excessive snoring or daytime drowsiness?
15.	☐	☐	Do you have any prosthetic heart valves?
16.	☐	☐	Do you have any prosthetic joints?
17.	☐	☐	Is there any chance you may be pregnant?