Patient Name: ______________________ Date of Birth: ______________

Date of Surgery: _____________ Surgeon's Name:__________________

Emergency Contact Name: ______________________________________

Emergency Contact Phone Number: _______________________________

OHOW PRESURGICAL QUESTIONNAIRE

(Please circle either YES or NO)

Do you have difficulty understanding English? YES (STOP) NO

Have you had any anesthesia/sedation at OHOW in last 90 days? YES NO

Please rate your overall health. GOOD NOT SO GOOD POOR

Do you smoke? YES NO

Does your weight interfere with activities of daily living such as walking, carrying groceries, or climbing 2 flights of stairs? YES NO

Are you on oxygen at home, have a productive cough **or** have trouble breathing when you lay flat?
YES NO

Do you have a seizure disorder? YES NO

Have you been told your blood pressure is poorly controlled? YES NO

Have you had any of the following?

Heart Attack:	YES	NO	Chest Pain (angina):	YES	NO	Irregular Heart Rate:	YES	NO
Heart Failure:	YES	NO	Heart Stents:	YES	NO	Shortness of Breath:	YES	NO
Dizziness:	YES	NO	Fainting:	YES	NO	Chest Pressure with Activity:	YES	NO

Are you a diabetic? YES NO

Do you have active cancer **or** have you had chemotherapy **or** radiation in the last year? YES NO

Do you have a battery operated implant **or** pacemaker? YES NO

Have you been told any of the following?
Snore: YES NO Stop Breathing when You Sleep: YES NO

Do you experience excessive daytime sleepiness? YES NO

Have you or anyone in your family experienced problems with anesthesia? YES NO

Please provide the name and phone number of your primary care doctor, any specialists you see, and the pharmacies where you get your prescriptions filled:

Name of Primary Care Physician: _________________________ Phone Number: ____________________
Name of Specialists: _____________________________________ Phone Number: ____________________
Name of Specialists: _____________________________________ Phone Number: ____________________
Name of Pharmacies you receive prescription medication from: __________________________________
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