



050001

PLACE LABEL HERE.  
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

**OUTPATIENT SURGERY HEALTH ASSESSMENT QUESTIONNAIRE**

IF YOU ARE TO RECEIVE A GENERAL ANESTHETIC OR SEDATIVE DRUGS, YOU **MUST BE ACCOMPANIED BY** SOMEONE WHO CAN TAKE YOU HOME FROM THE CENTER AND STAY WITH YOU FOLLOWING SURGERY. YOUR SURGERY MAY BE CANCELED IF THESE ARRANGEMENTS HAVE NOT BEEN MADE.

Name of the person who will take you home: \_\_\_\_\_

Telephone Number of the person who will take you home: ( \_\_\_\_\_ ) \_\_\_\_\_

**List allergies** (bad reaction to the following):  
Medicine:

Food:

**Are you allergic to latex** (rubber, elastic, balloons, tape, band-aids, or similar product)?  No  Yes

**List all medical illnesses you have had:**

**List any operations you have had:**  
Date            Operation

**List all medications you now take** (include dose and frequency):

**List any additional medication you have taken within the last year** (include dose and frequency):

**List any herbs, natural or homeopathic remedies or vitamins you use** (include dose and frequency):

**HAVE YOU EVER HAD:**

Surgery Requiring Anesthesia	No	Yes	Any Complication or Ill Effect Related to Anesthesia	No	Yes
Any Blood Relative with Muscular Dystrophy, Malignant Hyperthermia, or Other Neuromuscular Disorder	No	Yes	*Pneumonia	No	Yes
Any Blood Relative Who Had Anesthesia Complications of Any Kind	No	Yes	*Asthma or Hay Fever	No	Yes
Any Breathing Difficulty	No	Yes	*Chronic or Frequent Cough	No	Yes
Abnormal Chest X-ray	No	Yes	*Heart Disease or Heart Murmur	No	Yes
*Chest Pain or Angina Pectoris	No	Yes	*Heart Attack	No	Yes
*Shortness of Breath That Wakes You Up	No	Yes	*Palpitations or Irregular Heart Beat	No	Yes
*Abnormal Electrocardiogram	No	Yes	Fainting Spells	No	Yes
*High or Low Blood Pressure	No	Yes	Stroke	No	Yes
*Kidney Disease	No	Yes	Multiple Sclerosis, Muscular Dystrophy, Neuromuscular Disease, Malignant Hyperthermia	No	Yes
*Bladder/Prostate Problems	No	Yes	*Epilepsy or Seizures	No	Yes
Weakness of an Arm or Leg	No	Yes	Anemia (Low Blood Count)	No	Yes
Blood or Plasma Transfusions	No	Yes	Eye or Vision Problems	No	Yes
Excessive or Easy Bleeding	No	Yes	Heart Burn or Hiatal Hernia	No	Yes
Thyroid Disease	No	Yes	Stomach Ulcers	No	Yes
*Diabetes	No	Yes	Jaundice or Hepatitis	No	Yes
Motion Sickness, Nausea/Vomiting After Anesthesia	No	Yes	MRSA or VRE (requiring isolation)	No	Yes
			Exposure to AIDS	No	Yes

**WOMEN:**

Could You Be Pregnant?	No	Yes	What is Your Age _____
Are You Lactating?	No	Yes	What is Your Weight _____ (Now)
Date of Last Menstrual Period _____			_____ (One Year Ago)

**Patients with weight over 340 often require special precautions. If your weight is over 340, it is imperative that you notify UVA Outpatient Surgery prior to your day of surgery to avoid last minute cancellation.**

**DO YOU HAVE:**

A Cold	No	Yes	A Cough	No	Yes
Contact Lenses, Glasses	No	Yes	Chipped or Loose Teeth	No	Yes
Removable Dentures, Caps, Crowns, or Fixed Bridgework	No	Yes	Hearing Aid	No	Yes
Any Other Prosthesis	No	Yes	Much Anxiety About Your Pending Operation	No	Yes
AIDS or Related Diseases	No	Yes	Hepatitis	No	Yes
Special Needs	No	Yes	Ongoing Chronic or Acute Pain	No	Yes

**DESCRIBE THE FOLLOWING:**

Use of Alcohol: Never	Occasionally	Daily		
Have You Ever Been Treated For Alcoholism?	No	Yes		
Have You Ever Been Treated For Drug Abuse/Addiction?	No	Yes		
Do You Take Insulin (or Other Blood Sugar Medication)?	No	Yes		
Do You Use Tobacco?	No	Yes		
Cigarettes	Packs per Day	Cigars	Pipe	

**CHILDREN:**

*Was the patient born prematurely?	No	Yes
*Is the patient exposed to second hand smoke?	No	Yes
*Does the patient have a chronic cough?	No	Yes

**Sign Here:** \_\_\_\_\_ **Date:** \_\_\_\_\_

PATIENT OR PARENT'S SIGNATURE

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_