SCA Health
Franklin Surgical Center

Franklin Surgical Center
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(908) 766-5556

Pre-Operative Questionnaire

Patient Name:	Date of Birth:	Height:	Weight:
Surgeon:	Date of Procedure:	Procedure:	

Please fill out this questionnaire *to the best of your ability* and return to Franklin Surgical Center via mail to the address above or fax to 1-866-224-8187 at least 1 week prior to your procedure date. Failure to fill out this form correctly *may* delay your surgery.

Do you have or have you ever had any of the following. If *yes*, please check box and list date:

□ Stress test:	□ Heart echo (ultrasound):
□ Nuclear medicine heart scan:	□ Holter rhythm:
□ Heart catheterization:	□ Lung function test:
□ EKG:	□ Other:

In the past, have you ever been seen by a medical doctor? If *yes,* please check box & list name, phone number and location:

□ Primary Medicine _____ Location/Phone # _____
□ Heart Specialist (cardiologist) _____ Location/Phone # _____
□ Lung Specialist (pulmonologist) _____ Location/Phone # _____
□ Nerve Specialist (neurologist) _____ Location/Phone # _____
□ Other (specify) _____ Location/Phone # _____
□ Other (specify) _____ Location/Phone # _____

Do you perform regular exercise? □ Yes: what kind and how often? _____
□ No- if no, what limits you? _____

Do you have or have you ever had any of the following: If *yes*, please check box:

□ Chest pain, heart attack, heart valve issues, cardiac stents or other heart problems	□ Severe snoring, or sleep apnea (stopping breathing while asleep) □ Use of BiPAP or CPAP machine
□ Heart irregularities or palpitations	□ Asthma or wheezing □ Home oxygen
□ High blood pressure	□ Lung problem (such as COPD) or abnormal chest x-ray
□ Heart surgery or angioplasty	□ Chronic cough
□ Heart pacemaker and/or Defibrillator: type ____ model ____	□ Difficulty opening your mouth or moving your neck?
□ Abnormal echocardiogram (ECG)	□ Do you have problems swallowing?
□ Seizures or epilepsy	□ Shortness of breath walking and/or climbing stairs
□ Stroke or intermittent numbness, or black outs	□ Heartburn, hiatal hernia or acid reflux
□ History of fainting or dizziness	□ Involuntary weight loss (10-12 pounds in 6 months)
□ Do you smoke? If so, how much?	□ Stomach ulcers
□ Do you drink alcohol? If so, how much?	□ Back problems, fractures or herniated disc
□ Do you have a history of substance abuse? If so, how long in recovery? _____	□ Diabetes Insulin dependent: □ Yes or □ No A1C: _____
□ Rheumatoid arthritis	□ Kidney/bladder/urination problems
□ Thyroid problems	□ Liver problems
□ Prior bleeding or clotting disorders	□ Hepatitis or positive HIV test

Have you had any previous surgical operations? If yes, please list type of operation and the approximate year: □ Yes □ No
_____
_____

Have you or any of your close family members had serious problems with anesthesia? □ If yes, who? _____ □ No

Do you have any serious illness that we have not mentioned? If *yes*, please list below: □ Yes □ No
_____

I attest the above information is correct to the best of my knowledge.
Print Name: _____ Signature: _____ Date: _____
Form completed by: □ Patient □ Relative (specify relationship to patient _____)