Culpeper Surgery Center, LLC
Patient Health Assessment Questionnaire

To Our Patient:

We are pleased that you have chosen Culpeper Surgery Center for your health care. One of our goals is to expedite the pre-admission procedure because we know time is important to you. **We ask that you complete this questionnaire and return it to your surgeon. A nurse from the Surgery Center will be contacting you a few days prior to your scheduled surgery—if you are difficult to get in touch with please call the Surgery Center at 540-829-0700 (M-F 8:00-4:00).** The purpose of this call is for the pre-operative interview and instructions. Thank you for your cooperation, and we look forward to caring for you.

Staff at CSC

Patient Name:_____DOB_____

Family Doctor:_____Height:_____ Weight:_____

Allergies (food and medication): _____

_____ Latex Allergy? Yes No

Past Operations With Dates: _____

_____

Past Medical Illnesses: _____

_____

List of Medications Currently Taking (including Herbs, Vitamins, etc.): _____

_____

List of Any Other Medications Taken in the Last Year: _____

_____

Do you use tobacco? Yes No

#_____ packs per day
#_____ cigars per day
#_____ pipes per day
_____ snuff

Females:
Could you be pregnant? Yes No
Date of last menstrual period:
_____

Born premature? Yes No

DO YOU NOW HAVE:

Any infections	Yes	No	Eyeglasses or contact lenses (circle which one)	Yes	No
A cold	Yes	No			
Shortness of Breath with exercise	Yes	No	Hearing Aids	Yes	No
			Artificial Parts	Yes	No
Chronic Sinus Trouble	Yes	No	Dentures, caps, crowns or bridgework	Yes	No

HAVE YOU EVER HAD:

Asthma or Hayfever (circle which one)	Yes	No	Pneumonia	Yes	No
			Bronchitis	Yes	No
Trouble breathing	Yes	No	Abnormal Chest X-Ray	Yes	No
Chronic cough	Yes	No	Pulmonary Disease	Yes	No
Low of High Blood Pressure	Yes	No	Surgery requiring Anesthesia	Yes	No
(circle which one)	Yes	No	Any complications due to	Yes	No
Abnormal EKG	Yes	No	Anesthesia?		
Heart Disease of Murmur	Yes	No	Family history of	Yes	No
Chest Pain (Angina)	Yes	No	complications from anesthesia?		
Heart Attack	Yes	No			
Palpitations of Irregular Beats	Yes	No	Blood Transfusions	Yes	No
Problems with Bleeding	Yes	No	Thyroid Disease	Yes	No
Poor circulation to extremities	Yes	No	Back Problems	Yes	No
Diabetes	Yes	No	Eye Problems	Yes	No
Kidney problems of dialysis	Yes	No	Weakness	Yes	No
Liver Disease of Hepatitis	Yes	No	Have you been to a doctor other	Yes	No
(circle which one)			than your surgeon in the past year?		
Stroke	Yes	No	Are you able to support your own	Yes	No
Seizures	Yes	No	weight?		
Hiatal Hernia/Heartburn	Yes	No			
(circle which one)			Use of Alcohol: _____ Never		
Peptic Ulcers	Yes	No	_____ Occasional		
Sleep Apnea	Yes	No	_____ Daily		
			Have you ever been treated for		
			Alcoholism?	Yes	No

If there are any items you would like the physician to be aware of, please write out:

_____

_____

If you receive any form of anesthesia, you **MUST BE ACCOMPANIED BY A REPSONSIBLE ADULT WHO WILL DRIVE YOU HOME AND SOMEONE TO ASSIST YOU WITH DAILY ACTIVITES FOR THE REMAINDER OF THE DAY. You will not be permitted to drive, ride a bus, or take a taxi if anesthesia is given.** Your surgery may be cancelled if these arrangements have not been made.

Name of person who will take you home: _____

Telephone number of person who will take you home: ( )_____

_____ _____

Patient or Responsible Party Signature Date