Faith Surgical Center
3716 Standridge Dr Suite 100
The Colony, TX 75056

PATIENT QUESTIONNAIRE **EXPLANATION IS REQUIRED FOR ALL YES ANSWERS**

YES NO

☐ ☐ 1. Is there a language or learning barrier_____
☐ ☐ 2. Are there any religious/cultural needs_____
☐ ☐ **3. List ALL Allergies – drugs,food, latex, iodine, tape**_____
☐ ☐ **4. List ALL Previous Surgery/Hospitalization:**_____
_____
☐ ☐ 5. Do you have metal implants from previous surgeries?_____
☐ ☐ 6. Have you ever had a problem with anesthesia?_____
☐ ☐ 7. Has anyone related to you ever had a problem with anesthesia?_____
☐ ☐ 8. Are you under treatment for **high blood pressure**?_____
☐ ☐ 9. Have you ever had a heart attack?_____
☐ ☐ 10. Have you ever had angina or pain in your chest?_____
☐ ☐ 11. Do you have a heart murmur?_____
☐ ☐ 12. Have you ever had a stroke?_____
☐ ☐ 13. Have you had epilepsy, seizures, or fainting spells?_____
☐ ☐ 14. Do you have heartburn, hiatal hernia or ulcers?_____
☐ ☐ 15. Have you had asthma?_____
☐ ☐ 16. Have you had any difficulties with breathing?_____
☐ ☐ 17. Do you smoke? If so packs/day_____ Years smoked_____
☐ ☐ 18. Do you had any thyroid problems?_____
☐ ☐ 19. Do you have **diabetes**?_____
☐ ☐ 20. Do you have kidney disease?_____
☐ ☐ 21. Have you ever had Hepatitis?_____
☐ ☐ 22. Have you ever been jaundiced?_____
☐ ☐ 23. Do you have an arm or leg that becomes numb or weak frequently?_____
☐ ☐ 24. Do you have limited motion?_____
☐ ☐ 25. Have you taken aspirin in the last week? Herbal Medications?_____
☐ ☐ 26. Do you have any bleeding tendencies?_____
☐ ☐ 27. Have you taken any cortisone or steroids in the last 6 months?_____
☐ ☐ 28. Do you use any illicit drugs?_____
☐ ☐ 29. Do you have more than 2 alcoholic drinks per day? If so how many_____
☐ ☐ 30. Do you have any chipped or loose teeth, dentures, caps, bridgework, braces?_____
☐ ☐ 31. Do you wear contact lenses?_____
☐ ☐ 32. Could you be pregnant? _____
☐ ☐ 33. Do you have a cold, cough or flu like symptoms?_____

Return Visit Update:

Do you give authorization to leave health information by alternate means? Yes No

□ No change: □ Change listed Date: Signature:_____
□ No change: □ Change listed Date: Signature:_____
□ No change: □ Change listed Date: Signature:_____

X_____
PATIENT SIGNATURE DATE

Pre Op Intsructions: □ Left message with pt □ Unable to leave message
Call Date: Call Time: Staff Name:

Procedure time:_____**Arrive at the Center by:**_____ □ Please do not wear any perfume, creams or oils.

Have you had fever or flu like symptoms in the past 3 days? N Y If yes, have pt call PCP & reschedule

Have you or a member of your family traveled outside of the U.S. in the last 30 days? N Y Where?

□ Nothing to eat for 8 hours prior to your surgery □May bring glasses. □Do not wear contact lenses. □Wear comfortable clothes

□Bring insurance cards/forms. □Do not bring valuables and/or jewelry. □ Someone must drive you home

□ Take BP medication with sip of water □Hold Diabetic medication in am □ Bring asthma inhaler □ Sleep apnea/ bring CPAP machine

Notes:_____