Vipul T. Amin M.D.
Etowah Gastroenterology Associates, P.C.
1026 Goodyear Ave, Suite 201, Gadsden, AL 35903
PH :(256) 467-4477, FX :(256) 467-4830

Anesthesia Department

Pre-Surgical Patient Questionnaire

PLEASE FILL OUT AND BRING IT WITH YOU ON TESTING DAY

NAME: ________________________ **DATE:** ___________________

1. What is the procedure you are having today? _______________________________________
2. Any major illnesses other than childhood diseases? __________________________________
3. Have you ever had an operation? If so, please list them and the dates of surgery, if known
   ____
   ____
   ____

4. Please write in any medications, injections or pills that you take (this includes prescriptions drugs, over-the-counter drugs and vitamins)

   ____
   ____
   ____

   You may attach a printed list if you prefer

5. Do you have any allergies to specific medications? If so, please list them

   ____

   - o No Allergies
   - o No Prior reaction to Anesthesia
   - o No Blood Relative has had Reaction to Anesthesia

6. Weight ___________________________Height ________________________

7. **FEMALES:** If you are under 55 and have had a period within past year, you will be asked for a urine sample.

8. Date of last menstrual period: __________ How many pregnancies have you had? ______

9. How many children have you had? ______ How many miscarriages or abortions? ________

10. Is it possible you may be pregnant? ___________

11. Any problems with your blood pressure, heart or circulation? (include history of chest pain associated with the use of nitroglycerin) yes or no
    If yes, list ____

12. Any lung disease ((e.g. Bronchial asthma, emphysema), recent cough, cold or sore throat?
    Yes or no
    If yes, list ____

13. Any seizure, strokes, convulsions, blackouts, fainting spells, headaches? Yes or no
    If yes, list ____

14. Any disease of stomach/intestines? Yes or no
    If yes, list ____

15. Any disease of liver, jaundice, hepatitis, transfusion reaction? Yes or no
    If yes, list ____

16. Any bleeding disorder or bleeding tendency? Yes or no
    If yes, list ____

17. Kidney or bladder disease? Yes or no
    If yes, list ____

18. Diabetes or thyroid disease? Yes or no
    If yes, list ____

19. Do you have loose, false, chipped, capped, or bad teeth, bridges or dentures? Yes or no

20. Do you wear contact lenses? Yes or no

21. Have you taken cortisone by mouth in the past 12 months? Yes or no

22. Have you taken nerve pills or tranquilizers in the past 2 weeks? Yes or no

23. Do you have more than 2 alcoholic drinks per day? Yes or no

24. Do you or have you ever smoked? Yes or no
    If yes, How much? ________ If stopped, when? __________________