Montgomery Surgery Center

NURSING QUESTIONNAIRE FOR SURGICAL PATIENTS

Patient Name: _____ **Date of Birth:**_____

Surgery Date: _____ **Procedure:** _____ **Surgeon:**_____

Height: _____ **Weight:**_____ **Telephone Number:** _____

Allergies:_____

Please answer all of the following questions. For "YES" answers, please use blank space to provide details.

1. Have you been **hospitalized** within the past 3 months? ☐YES ☐NO
   If YES, reason: _____

2. Have you ever had a **heart attack** or **congestive heart failure**? ☐YES ☐NO
   If YES, circle all that apply and dates: _____

3. Have you ever had **heart catheterization, angioplasty, heart stent,** or **heart surgery**? ☐YES ☐NO
   If YES, circle all that apply and dates: _____

4. Do you have an **abnormal heartbeat, angina** or **chest pain**? ☐YES ☐NO
   If YES, circle all that apply and describe: _____

5. Do you have an **implanted defibrillator**? ☐YES ☐NO
   If YES, have your doctor **fill out implanted device paperwork.**

6. Do you see a Cardiologist? ☐YES ☐NO
   If YES, reason: _____

   Please provide Cardiologist's name and telephone number:_____

7. Are you taking **blood thinners**? ☐YES ☐NO
   If YES, list: _____

8. Are you on **dialysis**? ☐YES ☐NO
   If YES, type and how often: _____

9. Do you **currently** have an **Upper Respiratory Infection, Acute Bronchitis, Flu, a Cold, or had one in the last 2 weeks**?
   If YES, circle all that apply and dates: _____ ☐YES ☐NO

10. Do you use **steroids or inhalers** for your breathing? ☐YES ☐NO
    If YES, is your breathing condition stable and/or under control? ☐YES ☐NO

11. Do you have **sleep apnea**?
    If yes, do you **use a C-PAP machine (with or without oxygen) to sleep?** ☐YES ☐NO

12. Have you ever had problems with the **insertion of a breathing (endotracheal) tube**? ☐YES ☐NO
    If YES, describe: _____

13. Do you have any **significant neck problems** or have you had prior **neck surgery**? ☐YES ☐NO
If YES, list: _____

14. Have **you** or **any family members** had **major problems** with anesthesia in the past? ☐YES ☐NO
If YES, describe: _____

15. Do **you** or **any family members** have **Malignant Hyperthermia**? ☐YES ☐NO
If YES, list who:_____

16. Do you have **Syncope** (fainting spells)? ☐YES ☐NO

17. Have you ever had **a stroke or mini stroke**? ☐YES ☐NO
If YES, dates and any residual deficits: _____

18. Can you **lie flat on your back** for about 30 minutes? ☐YES ☐NO

19. Do you have **Diabetes**? ☐YES ☐NO
If YES, do you take medication for your Diabetes? ☐YES ☐NO
Please list medications:_____

20. Do you take any **medications for weight loss such as Ozempic or Wegovy?** ☐YES ☐NO
If YES, please list medications:_____

21. Have you been vaccinated for Covid-19? ☐YES ☐NO
If YES, which vaccine and how many doses? _____

22. WHAT OTHER MEDICATIONS DO YOU CURRENTLY TAKE?

MEDICATION	DOSAGE	FREQUENCY