OUTREACH PROGRAM PRE- SURGERY ASSESSMENT

Name:		Height: (inches)		Age:	
E-mail:		Weight: (pounds)		BMI:	
Address:		City, State, Zip			
*Telephone:	(Home): (Cell) :	Maximum Weight:		*Sex:	
*List All Medicine Allergies:		Date of Birth:			
*Name of person to contact (in case of emergency):		*Emergency Phone #:			

For the Following Questions, Please Indicate "Yes" "No" or "Do Not Know". *Please answer all of the questions.*

	Question			
1.	Are you currently taking any medications? If Yes, please list: ____________________	☐ Yes	☐ No	☐ Do Not Know
2.	Have you ever been treated for cancer with chemotherapy or radiation therapy? If yes: when: ____________________	☐ Yes	☐ No	☐ Do Not Know
3.	Do you currently have any problems with your: a) Liver	☐ Yes	☐ No	☐ Do Not Know
	b) Kidneys	☐ Yes	☐ No	☐ Do Not Know
	c) Spleen	☐ Yes	☐ No	☐ Do Not Know
	d) Blood	☐ Yes	☐ No	☐ Do Not Know
4.	Have you or anyone in your family ever had a serious bleeding problem?	☐ Yes	☐ No	☐ Do Not Know
5.	Have you ever had prolonged or unusual bleeding from tooth extractions, cut, surgery or nosebleed?	☐ Yes	☐ No	☐ Do Not Know
6.	Do your gums bleed when you brush your teeth?	☐ Yes	☐ No	☐ Do Not Know
7.	Are you pregnant?	☐ Yes	☐ No	☐ Do Not Know
8.	Is there any possibility that you are pregnant?	☐ Yes	☐ No	☐ Do Not Know
9.	Have been told you have diabetes?	☐ Yes	☐ No	☐ Do Not Know
10.	Do you wake up to urinate more than once at night?	☐ Yes	☐ No	☐ Do Not Know
11.	Do you have muscle cramps or pains?	☐ Yes	☐ No	☐ Do Not Know
12.	Do you have problems with your lungs or chest? (e.g., chest pain, skipped heart beats, high blood pressure, shortness of breath, emphysema, asthma, bronchitis) underline all that apply.	☐ Yes	☐ No	☐ Do Not Know

13. Do you have a cough, or cough frequently? ☐ Yes ☐ No ☐ Do Not Know

14. Do you have epilepsy or suffer from fits or seizures? ☐ Yes ☐ No ☐ Do Not Know

15. Do you have neck or back problems? ☐ Yes ☐ No ☐ Do Not Know

16. Are you scheduled to have an operation? ☐ Yes ☐ No ☐ Do Not Know
If Yes, what operation? ______________________________

If you wish to expand in any area or have additional information please add on to this form at the bottom.

17. *Any Medical/physical problems (i.e., sleep apnea, high blood pressure, diabetes, high cholesterol, blood diseases, neurological disorders, etc)? ☐ Yes ☐ No ☐ Do Not Know
If Yes, please list: ______________________________

18. Is there history in your family of diabetes, cancer and/or hypertension? ☐ Yes ☐ No ☐ Do Not Know
If Yes, please indicate which ones: ______________________________

19. Have you had any surgeries (i.e., gallbladder, appendix, hernia, heart, etc.)? ☐ Yes ☐ No ☐ Do Not Know
If Yes, please list: ______________________________

20. Do you have any adverse reaction to anesthesia? ☐ Yes ☐ No ☐ Do Not Know
If Yes, please indicate the reaction: ______________________________

21. Do you have dentures, dental implants, or caps? ☐ Yes ☐ No ☐ Do Not Know
If Yes, please indicate where: ______________________________

22. Do you have any children? If so, how many? ☐ Yes ☐ No

23. Do you have heavy periods? ☐ Yes ☐ No

24. Do you smoke? If so, how many cigarettes a day ☐ Yes ☐ No

25. Do you drink? If so, how many? ☐ Yes ☐ No

26. Do you do drugs? If so, what kind & how often? ☐ Yes ☐ No

Additional Information