Northern Baltimore
SURGERY CENTER

Patient Medical Questionnaire

To be completed prior to surgery

Patient's Name:	Date of Birth:
Phone number:	Date form completed:
Name of person driving you home?	
Will this person need to be called from the center? ❑ No, ❑ Yes, Ph:	

Medical Problems – Please check all that apply.

Heart Murmur		Bleeding Disorders		Hepatitis
Mitral Valve Prolapse		Epilepsy / Seizures		Reflux
Endocarditis		Arthritis		Hiatal Hernia
Heart Disease		Gallbladder Problems		Ulcer
Pacemaker/Defibrillator		Kidney Problems		Myalgia
Heart Attack, M.I.		Liver Problems		High Cholesterol
Hypertension, High BP		Glaucoma		Vertigo
Stroke / TIA		Cataracts		Prostate / BPH
COPD		Anemia		Cancer
Emphysema		Thyroid Problems		Sleep Apnea
Asthma		Diabetes		HIV History
Have your or your family had a History of Malignant Hyperthermia		History of illegal IV drug use Last time used _____		

HAVE YOU, YOUR RELATIVES, OR CLOSE ACQUAINTANCES TRAVELED INTERNATIONALLY IN THE PAST 21 DAYS ❑ YES WHERE_____ (PLEASE NOTIFY YOUR PRIMARY PHYSICIAN AND SURGEON) ❑ NO

List all surgery you have had in the past.	Year of surgery

Do you use alcohol, tobacco, narcotic or barbiturates?	❑ Yes	❑ No
Comments:		
Have you ever had any problems with anesthesia or IV Sedation?	❑ Yes	❑ No
If yes, describe:		
Have you been told you have "difficult veins to access"?	❑ Yes	❑ No
Comments:		

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