



Pre-Operative Clearance Questionnaire

*The information you supply below assists in the development of your pre-operative care plan.
Please complete this questionnaire accurately and completely.*

Patient Name _____

Age _____ **Weight** _____ **Height** _____ **Date** _____

Allergies _____

Current Medications – Prescription and Non-Prescription

(Include all over-the-counter medications; herbal supplements; complementary or alternative medications)

Prior Operations

**Your response to the following questions will help us determine and provide treatment
that is best for you.**

Yes No Question

- Have you recently had a cold or flu?
- Are you allergic to latex (rubber) products?
- Have you experienced chest pain?
- Do you have a heart condition?
- Do you have hypertension (high blood pressure)?
- Do you experience shortness of breath?
- Do you have asthma, bronchitis, or any other breathing problems?
- Do you (or did you) smoke?
IF YES: Packs/day _____ Number of years _____ Date you quit _____

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Yes No Question

- Do you consume alcohol?
IF YES: Drinks/week _____
- Do you take, or have taken, recreational drugs?
- Have you taken cortisone (steroids) in the last 6 months?
- Do you take any nonsteroidal, anti-inflammatory drugs (NSAIDs)?
- Do you take herbal supplements, or complementary or alternative medications?
IF YES: How recently? _____
- Do you have diabetes?
- Have you had hepatitis, liver disease, or jaundice?
- Do you have a thyroid condition?
- Do you have, or have ever had, kidney disease?
- Do you have ulcers or other stomach disorders?
- Do you have a hiatal hernia?
- Do you have back or neck pain?
- Do you have numbness, weakness, or paralysis of your extremities?
- Do you have any muscle or nerve disease?
- Do you, or any of your family, have sickle cell trait?
- Have you, or any blood relatives, had difficult with anesthesia?
- Do you have any bleeding disorders?
- Do you have loose, chipped, or false teeth? Bridgework? Oral piercings
- Do you wear contact lenses?
- Have you ever received a blood transfusion?
- Are you pregnant? **Women**
- Do you take, or have you taken, Viagra, Cialis, or other erectile dysfunction medications? **Men**

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