

UROLOGY ASSOCIATES, P.C.

Day-Op Center
833 Northern Blvd
Great Neck, NY 11021



PRE-OPERATIVE QUESTIONNAIRE

Have you ever had or been treated for any of the following?

	YES	NO
1. HEART		
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Angina.....	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations/Abnormal Rhythm.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse/Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
Circulation/Vascular Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
2. LUNGS		
Breathing Problems/Shortness of Breath.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a nasal BiPap /CPAP machine at home?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes do you use it?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you had sleep apnea?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you sleep poorly or snore loudly?.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia/Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever/Seasonal Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
3. HEAD		
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>
Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis/Weakness/Numbness.....	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury.....	<input type="checkbox"/>	<input type="checkbox"/>
4. GASTROINTESTINAL		
Ulcers/Stomach Pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis/Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/Hiatal Hernia.....	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis.....	<input type="checkbox"/>	<input type="checkbox"/>

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	YES	NO
5. KIDNEYS		
Dialysis.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/Bladder Stones.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney-Bladder Infections.....	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
6. ENDOCRINE		
Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Insipidus.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Steroid Use/Cortisone.....	<input type="checkbox"/>	<input type="checkbox"/>
7. CANCER		
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
8. GENERAL		
Are you pregnant or lactating? Date of your last menstrual period _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of bleeding problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you take Aspirin/Motrin Daily?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you take Coumadin, Plavix or Blood Thinners?.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion Reactions?.....	<input type="checkbox"/>	<input type="checkbox"/>
Height _____ Weight _____		
9. PERSONAL HABITS		
Do you smoke?.....	<input type="checkbox"/>	<input type="checkbox"/>
Packs per day _____ Years Smoking _____ Year Stopped _____		
Alcohol: Any history of drinking (beer, wine, liquor).....	<input type="checkbox"/>	<input type="checkbox"/>
Drugs: Recreational drugs (Marijuana, Cocaine, etc).....	<input type="checkbox"/>	<input type="checkbox"/>
Pain Killers _____		
Do you wear dentures?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a hearing aid(s)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an artificial limb?.....	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY	
Food/Latex Allergy: <input type="checkbox"/> No <input type="checkbox"/> es. If Yes, list: _____	
Medication Allergy: <input type="checkbox"/> No <input type="checkbox"/> es. If Yes, list: _____	
Daily Medications: _____	
Previous Surgery: _____	
Have you or a family member ever had a reaction to anesthesia? (explain) _____	
Other Medical Conditions? _____	

