

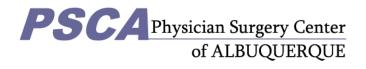
Preoperative Questionnaire

Dear Patient,

This questionnaire will help your anesthesia team determine what if any preoperative work up will be needed prior to your surgery and help them gather all available medical information about you. Please fill it out as best you can. This information will help to avoid any delay in your surgery.

In some cases, we will contact you for a preoperative evaluation over the phone. If you have any questions, you can contact us at **505-639-4640**. Thank you!

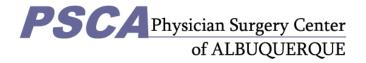
Name:		Date of	Birth:	
Patient Age:	Patient Height:	Patient Weight:		
Phone #:		Email:		
Surgeon:		Date of Surgery:		
Name of Person comp	leting this form:		Relation:	
Do you have prima	ry care provider: □ Yes	No		
Primary care provide	er name:			
Primary care provide	er phone number:			
Date of last visit with	n primary care provider: _			
Specialist you are o	currently seeing or have	seen in the last 5 years:		
Cardiologist Name:			Phone:	
Pulmonologist Nam	e:		Phone:	
Other Name:			Phone:	
Other Name:			Phone:	
Do/Did you ever us	se illegal drug(s) ? 🗆 Ye	es 🗆 No		
What drug(s):				
Do/Did you ever us	se marijuana? 🗆 Yes 🗆	No		
How often:				
	/ drugs? □ Yes □ No			



Can you climb a flight of stairs? Yes No						
		egularly, play tennis, able to mow lawn, poor exercise bughout the day)				
Have very area have diamen	ad with any of the fallowing.					
☐ Kidney Disease	ed with any of the following: □N/A □ Asthma	☐ Tuberculosis				
☐ Emphysema	☐ GERD/Reflux/Heartburn	☐ Hiatal Hernia				
☐ Cancer	☐ Hepatitis	☐ Cirrhosis				
☐ Seizure	☐ Diabetes	☐ Thyroid problem				
☐ HIV/AIDS	☐ Sleep Apnea	☐ Alzheimer's				
☐ Parkinsons	☐ Demintia	☐ Cognitive Impairments				
☐ Yes ☐ No	to you ever had a major complication ting/blood or bleeding disorders	n that was related to receiving anesthesia? ✓es □No				
	ed with any cardiac issues: \square N/A					
☐ Heart Murmurs	☐ Pacemaker	☐ Angina				
☐ Irregular Heartbeat	☐ Ablation	☐ Congestive Heart Failure				
☐ AFIB	☐ Heart stents	☐ AICD				
☐ Coronary Artery Disease		☐ Heart Valve Issues				
☐ High Blood pressure						
☐ Heart Attack	☐ Other:					
Have you had an EKG within	the last year: ☐ Yes ☐ No					
Do you have diabetes? ☐ Y	es 🗆 No					
☐Type I ☐Type II						
Do you take any diabetes me	edication: \square Yes \square No (if yes please	list below in medications section)				
Do you have a history of clay	ustrophobia, anxiety, depression, or	DTSD2 Ves No				
-	istrophobia, anxiety, depression, or					
ii yes, piease describe						
Do you have a history of falls	s, problems with mobility or paralysi	S Vos No				
If yes please describe.	s, problems with mobility of paralys	3; L 163 L INO				



	Past Surgery		Year	
			se list all allergies and reactions below)	
Allergy:	Reaction:	Allergy:	Reaction:	
Allergy:	Reaction:	Allergy:	Reaction:	
Allergy:	Reaction:	Allergy:	Reaction:	
Allergy:	Reaction:	Allergy:	Reaction:	
Allergy:	Reaction:	Allergy:	Reaction:	
Allergy:	Reaction:	Allergy:	Reaction:	
Allergy:	Reaction:	Allergy:	Reaction:	



Medication List

Please use this sheet to list all your medications. Please include vitamins, minerals, herbal supplements and any other over the counter (OTC) medicines that you take, even if they were not prescribed by your doctor

☐ I do not currently take any medications, vitamins, or supplements

List all medications the patient is cu products	rrently taking including p	prescription, OTC, PRN, vitan	nins, topical and herbal
Medication/Vitamin/Supplement Name	How much do you take?	How often do you take this medication?	Reason for Medication