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Patient Name ___________________________________ Date of Birth ____________
Surgical Procedure_______________________________

Check "YES" or "NO" for each of the following:

1- Have you ever had problems with your heart? ------------------------------------ ( ) Yes ( ) No
If Yes, please respond to the following:
Have you ever had a heart attack or a cardiac arrest? -------------------- ( ) Yes ( ) No
Within the last 3 months -- ( ) Yes ( ) No
Do you have a history of chest pain or angina? ---------------------------- ( ) Yes ( ) No
If so, have your symptoms increased recently? ---------------------------- ( ) Yes ( ) No
Do you have a history of congestive heart failure? ------------------------ ( ) Yes ( ) No
If so, have your symptoms increased recently? ---------------------------- ( ) Yes ( ) No
Do you have a history of a cardiac arrhythmia (irregular heart beat)?- ( ) Yes ( ) No
If so, do you have medication or treatment? -------------------------------- ( ) Yes ( ) No
Do you have any problems with your heart valves? ---------------------- ( ) Yes ( ) No
If so, does this problem limit your physical activity? ---------------------- ( ) Yes ( ) No

2- Do you have high blood pressure? -- ( ) Yes ( ) No
If Yes, do you take medications or treatment? ------------------------------------ ( ) Yes ( ) No

3- Are you a diabetic? --- ( ) Yes ( ) No
If Yes, do you use insulin? -- ( ) Yes ( ) No

4- Have you had a stroke or TIA (mini-stroke) or seizure? ------------------------ ( ) Yes ( ) No
If Yes, describe ____

5- Have you had any trouble with your lungs or breathing? ----------------------- ( ) Yes ( ) No
If Yes, check one:
( ) Asthma ( ) Emphysema(COPD) ( ) Bronchitis ( ) Other _________________
Have you been hospitalized for this problem? -- ( ) Yes ( ) No
Does this problem limit your physical activity? -- ( ) Yes ( ) No
Date and location of your last chest x-ray? __________________________________

6- Have you had liver problems or hepatitis? -- ( ) Yes ( ) No
If Yes, check one:
( ) Hepatitis A ( ) Hepatitis B ( ) Hepatitis C ( ) Don't know
Describe other liver problems: ____
Date and location of your last liver function test: ______________________________

7- Have you ever had problems with kidney function? ------------------------------ ( ) Yes ( ) No
If Yes, describe problem ____
Do you have renal failure? --- ( ) Yes ( ) No

8- Have you ever been treated for cancer? -- ( ) Yes ( ) No
If Yes, please list types of cancer: ____
Did you receive radiation therapy -- ( ) Yes ( ) No

9- Do you have a bleeding disorder, bruise easily, or take blood thinners?------ ( ) Yes ( ) No
If Yes, please describe: ____

10- Is there any chance you could be pregnant? -------------------------------------- ( ) Yes ( ) No

11- Do you take a diuretic (water pill), digoxin, or a steroid? ---------------------- ( ) Yes ( ) No

12- Have you been treated for TB (tuberculosis) ---------------------------------------( ) Yes ( ) No

List dates of treatment: ____________________

13- Do you smoke cigarettes? --( ) Yes ( ) No
Approximate number of packs a day ____________________
When did you last smoke? ____________________

14- Do you drink alcohol? --- ( ) Yes ( ) No
Approximate number of drinks per day ____________________

15- Have you or family members had major problems with anesthesia? -------- ( ) Yes ( ) No
If Yes, please describe ____________________

16- Do you have a hiatal hernia, frequent heartburn, or food regurgitation? ---- ( ) Yes ( ) No

17- Have you seen a medical physician (internist, cardiologist, etc.) within the last six months? ( ) Yes ( ) No
Physician: ____________________
If so, has your health worsened in any way since your last visit? ------ ( ) Yes ( ) No

18- Please list any other medical problems not discussed above: ____________________
____

ACTIVITY LEVEL

In the past month, have you experienced difficulty:

- walking indoors around your home ( ) Yes ( ) No
- walking a block or two on level ground ( ) Yes ( ) No
- Doing light work such as washing dishes? ( ) Yes ( ) No
- Climbing a flight of stairs or walking up a hill? ( ) Yes ( ) No
- Participating in moderate exercise such as golf, dancing, etc.? ( ) Yes ( ) No
- Doing heavy work around your home, like scrubbing floors or yard work? ( ) Yes ( ) No
- Participating in strenuous activities like running or bending? ( ) Yes ( ) No
- If you have answered Yes, is there a specific medical condition that limits your level of activity (example: arthritis or angina)
- Specifically, are you limited with shortness of breath? ( ) Yes ( ) No

Please list all medications: ____________________
____

Please list allergies: ____________________
____

Please list prior surgeries: (if any) ____________________
____

If form filled in by patient ____________________ Date ____________________
(signature)

If form filled by person other than patient ____________________Date ____________________
(signature)