NORTHEAST ALABAMA SURGICAL ASSOCIATES

Patient Questionnaire

Name: ____________________________________ Age: _______Sex: ☐ Male ☐ Female

Height: ________________ Weight:______________ Dominant Hand: ☐ Right ☐ Left

Name of physician who referred you:____

Name of your family physician: ____

Name of your cardiologist :____

Why are you seeing the surgeon today? ______________________________________

____

Please Circle Yes or No in answer to the following questions:

Have you ever had a stroke or TIA?	Yes	No
Have you ever had epilepsy, blackouts or seizures?	Yes	No
Do you have numbness or weakness in your arms or legs?	Yes	No
Have you had any weight loss or poor appetite?	Yes	No
Have you had any fever, chills or "night sweats"?	Yes	No
Have you ever had a heart attack?	Yes	No
Have you ever had heart trouble or a "heart cath" study?	Yes	No
Have you ever had a heart stent or coronary bypass surgery?	Yes	No
Have you ever had fluid in your lungs?	Yes	No
Do you have high blood pressure?	Yes	No
Have you ever been treated for an irregular heartbeat?	Yes	No
Do you ever have chest pain, angina or chest tightness?	Yes	No
Do you ever have difficulty breathing?	Yes	No
Do you have asthma, bronchitis, or emphysema?	Yes	No
Does climbing one flight of stairs make you short of breath?	Yes	No
Does walking make you legs hurt?	Yes	No
Do you smoke?	Yes	No
Have you had liver disease, jaundice, or a history of hepatitis?	Yes	No
Do you drink more than 3 drinks of alcohol in a week?	Yes	No
Do you have indigestion, heart burn, reflux or hiatus hernia?	Yes	No
Have you had stomach ulcers or intestinal bleeding?	Yes	No
Do you have pain during or after eating?	Yes	No
Do you have a history of thyroid problems?	Yes	No
Do you have a history of diabetes?	Yes	No
Do you have a history of kidney problems?	Yes	No
Do you have problems with blood clots or excessive bleeding?	Yes	No
Do you have arthritis, or pain in your neck or back?	Yes	No
Do you have any non-healing or slowly healing wounds?	Yes	No
Do you use a wheelchair, crutch or cane?	Yes	No
Have you or a family member had a reaction to anesthetics?	Yes	No
Do you think you may be pregnant?	Yes	No
Have you ever had cancer?	Yes	No
Have you ever had problems during or after an operation?	Yes	No

Please Sign Here:_______________________________ Today's Date:____________________