JEFFREY D. RAWNSLEY, M.D., M.S.

PATIENT QUESTIONNAIRE

Patient Last Name _____ First Name _____

Age:_____ Sex: F ❑ M ❑ Height:_____ Weight: _____

Allergies: List any food, medication or environmental allergies:

_____

_____

Medications: List any currently taken including non-prescription drug:

_____ _____ _____ _____

_____ _____ _____ _____

List any other medications taken within the past three months:

_____ _____ _____ _____

_____ _____ _____ _____

Smoking: Number of years:_____ Number of cigarettes per day:_____

Ever quit: No ❑ Yes ❑ When: _____ Smoke a pipe or cigar: No ❑ Yes ❑

Alcohol: How much beer, wine or liquor do you drink?

_____

Medical History: Have you ever been told you had any of the following?

Emphysema/Asthma: No ❑ Yes ❑ • Heart Disease: No ❑ Yes ❑ • Cancer: No ❑ Yes ❑ • Diabetes: No ❑ Yes ❑ • Arthritis: No ❑ Yes ❑

_____

Operations: List previous surgery, dates and complications:

_____

_____

_____

Anesthesia: Describe any problems you have had with Anesthesia:

_____

_____

Has anyone in your family had a problem with Anesthesia? No ❑ Yes ❑

If yes, please describe: _____

_____

(Female): Date of last menstrual period: _____

— Please complete the other side —

PATIENT QUESTIONNAIRE

— CONTINUED —

PAST MEDICAL HISTORY	NO	YES
Have you had any recent weight loss?	☐	☐
Fever or chill in the past two weeks?	☐	☐
History of frequent headaches?	☐	☐
Have you had any change in your vision?	☐	☐
History of bleeding gums, nosebleeds?	☐	☐
Do you have any sinusitis?	☐	☐
Sore throat within the past two weeks?	☐	☐
Do you have a chronic cough?	☐	☐
Is there sputum production with cough?	☐	☐
Any night sweats?	☐	☐
Have you ever had pneumonia?	☐	☐
Do you ever get palpitations?	☐	☐
Do you get chest pains at rest?	☐	☐
Do you get chest pains with activity?	☐	☐
Is chest pain relieved with nitroglycerin?	☐	☐
Do you ever get short of breath?	☐	☐
Ever have ankle swelling?	☐	☐
Do you ever have high blood pressure?	☐	☐
Do you ever get pain in your legs?	☐	☐
Ever have a peptic or stomach ulcer?	☐	☐
Ever been diagnosed with hiatal hernia?	☐	☐
Do you have frequent nausea or vomiting?	☐	☐
Do you have any abdominal pain?	☐	☐
Have you ever had jaundice?	☐	☐
Do you have any pain on urination?	☐	☐
Do you ever have urinary incontinence?	☐	☐
Is there any blood in your urine?	☐	☐
Ever have a thyroid disorder?	☐	☐
Do you have limited motion in your joints?	☐	☐
Are you anemic *(low iron)*?	☐	☐
Do you bruise easily?	☐	☐
Have you ever "blacked out"?	☐	☐
Have you ever had a stroke?	☐	☐
Have you ever had any seizures?	☐	☐
Do you have any tumors?	☐	☐
Have you ever been treated for depression or anxiety?	☐	☐
Do you have any communicable diseases?	☐	☐
Have you ever had tuberculosis?	☐	☐
Have you ever had hepatitis?	☐	☐
Do you have any implanted devices such as a shunt, pump or pacemaker?	☐	☐
Do you have any chipped or loose teeth?	☐	☐
Do you have dentures or a bridge?	☐	☐

Physician Signature: _____ Date _____