DO YOU NOW OR HAVE YOU EVER HAD	Y	N	PLEASE LIST OTHER MAJOR ILLNESS / DISEASES
HEART DISEASE			
CHEST PAIN			
ANKLE SWELLING			
PACEMAKER/IRREGULAR HEARTBEAT			
HIGH BLOOD PRESSURE			
BRONCHITIS / EMPHYSEMA			
ASTHMA / WHEEZING			
HEREDITARY BLEEDING PROBLEMS			
DIABETES			
LIVER DISEASE / JAUNDICE / HEPATITIS			
AIDS / HIV			
DRUG OR ALCOHOL ABUSE			
HIATAL HERNIA / ULCERS / HEARTBURN			
EPILEPSY / CONVULSIONS / SEIZURES			
BACK / NECK PROBLEMS			
STROKE / TIA			
CANCER			
HAVE YOU HAD	**Y**	**N**	**SURGERIES / HOSPITALIZATIONS**
ANTICOAGULANTS/BLOOD THINNER IN PAST MONTH			
ANY DIET PILLS IN THE LAST MONTH			
CORTISONE / STEROIDS PAST YEAR			
RECENT COUGH OR COLD			
PREVIOUS ANESTHETICS			
BAD REACTION TO ANESTHESIA			
RELATIVES WITH ADVERSE REACTIONS TO ANESTHESIA			
COULD YOU BE PREGNANT?			
LAST MENSTRUAL PERIOD DATE			
ARE YOU AWARE OF THE RISK OF EATING OR DRINKING THE DAY OF ANESTHESIA?			
DO YOU	**Y**	**N**	
HAVE ANY PHYSICAL RESTRICTIONS			
HAVE TROUBLE WALKING 1 BLOCK			
HAVE FALSE / CAPPED / LOOSE TEETH			
WEAR CONTACT LENSES, GLASSES,			
HEARING AIDS, FALSE EYE *(CIRCLE)*			
DRINK ALCOHOL / SOCIAL DRUG USE AMT _____			
USE TOBACCO NOW? AMT _____			
USE TOBACCO IN PAST YEARS _____			

PRINT NAME:	**PATIENT SIGNATURE:**	**DATE:**
PRINT NAME:	**PATIENT SIGNATURE:**	**DATE:**
PRINT NAME:	**PATIENT SIGNATURE:**	**DATE:**
PRINT NAME:	**PATIENT SIGNATURE:**	**DATE:**

AGE:	**HEIGHT:**	**WEIGHT:**	**HOME PHONE**	**CELL/WORK PHONE**	**OK TO CALL YOU AT WORK?** ☐ YES ☐ NO

SIERRA AMBULATORY SURGERY CENTER
PAIN HEALTH QUESTIONNAIRE

Patient Label