
PRE-OPERATIVE QUESTIONNAIRE

Patient Name: _____ **Chart #:** _____ **Date:** _____

PLEASE CHECK ALL THAT APPLY AND EXPLAIN IF NEEDED:

- Have you had **trouble with excessive bleeding** from previous surgeries? **Yes** **No** _____

- Do you take **Aspirin** or **Baby Aspirin**
 - Coumadin**
 - Plavix**
 - Other blood thinners** _____

- Do you have **trouble with numbing medicine** such as Lidocaine/Xylocaine or Epinephrine? **Yes** **No**

- Do you have **Artificial Joints**
 - Implants**
 - Replacement Heart Valves** _____

- Do you have a **Pacemaker**
 - Defibrillator** _____

- Have you been told to take **antibiotics before or after** **Surgery**
 - For the Dentist** _____

- Do you have trouble with **Wound Healing**
 - Thick scars**
 - Keloids** _____

- Do you have **Uncontrolled High Blood Pressure**
 - Recent Chest Pain**
 - History of Heart Attacks**
 - Mitral Valve Prolapse**
 - Glaucoma**
 - HIV or AIDS**
 - Hepatitis** _____

- Are you **Pregnant or Breast Feeding?** **Yes** **No** _____

- Have you ever had problems with **Antibiotic Ointments**
 - Skin anti-septics**
 - Adhesive tape**
 - Wound Dressings** _____

Patient Signature