

ADULT HEALTH QUESTIONNAIRE PAGE 2

PLEASE COMPLETE BOTH SIDES OF THIS FORM

YES	NO	Please check the "Yes" or "No" box for each of the following questions. If your answer is "Yes", please circle appropriate response.	
		Blood or bleeding problems?	Anemia / Poor blood clotting / Too much clotting / Deep Vein Thrombosis
		Do you use aspirin or blood thinners?	Last use:
		Thyroid problems?	Hyperthyroid / Hypothyroid
		Dental or jaw problems?	Dentures / Caps / Loose teeth / TMJ / Trouble opening mouth
		Vision problems?	Glaucoma / Cataract / Eyeglasses / Contacts / Blindness
		Hearing / Language needs?	Hearing Aid / Deafness / Interpreter needed
		Do you use alcohol?	How much?
		Do you use herbal remedies?	Type:
		Do you use recreational drugs?	Type:
		Would you accept blood in a life threatening emergency?	
		Any possibility of pregnancy?	

What is the name and phone of your regular Medical Doctor ? _____
When was your last checkup? _____

If you have heart problems, what is the name/phone number of your Cardiologist? _____
When was your last checkup? _____

When did you have your last electrocardiogram (EKG or ECG)? _____

Have you ever had a treadmill test? _____ If so, when? _____

Have you ever had an angiogram? _____ If so, when? _____

Have you ever had an echocardiogram of the heart? _____ If so, when? _____

Name of the responsible adult who will drive you home and be available to assist you as needed for the next 24 hours:

Cell: _____ Home: _____

Patient Signature

Date/Time

Reviewing RN's Signature

Date/Time

You may mail this form to: Santa Barbara Surgery Center
3045 De La Vina St.
Santa Barbara, Ca. 93105 TEL: 805-569-3226

You may fax this form to: 1-866-297-5257
This is a secure, private fax machine

We thank you for taking the time to provide us with this important information!