



## Patient Information Packet

### **Contents:**

- 1) Adult Health Questionnaire
- 2) Patient Medication List

### **Instructions:**

- 1) Please fill out both pages of the Adult Health Questionnaire
- 2) Please fill out the Patient Medication List

Please mail the completed forms in the enclosed pre-addressed/ pre-stamped envelope to the Santa Barbara Surgery Center a minimum of 5 business days before your scheduled appointment.

If you are unable to return the forms by mail 5 days prior, please drop them off in person or fax them to (866) 297-5257. When faxing, please remember to fax both sides of the Adult Health Questionnaire.

If you have any questions or concerns, please feel free to contact the Santa Barbara Surgery Center Pre-Op Department at (805) 569-2026.



## SANTA BARBARA SURGERY CENTER ADULT HEALTH QUESTIONNAIRE PAGE 1

This health questionnaire will help us plan your care at the Santa Barbara Surgery Center. Please return the questionnaire to our center as soon as possible: either by mail or fax (see below). You will receive a phone call from the preop nurse before your surgery date to go over your health, answer questions, and to review instructions. Your physician Anesthesiologist will talk to you on the day of surgery.

**DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE NIGHT BEFORE YOUR SURGERY/PROCEDURE.\***

**\*IF YOUR SCHEDULED PROCEDURE TIME IS AFTER 12 NOON, YOU MAY HAVE PLAIN OR BUTTERED TOAST AND WATER UNTIL 6AM THE MORNING OF YOUR SURGERY/PROCEDURE. AFTER 6AM YOU ARE TO HAVE NOTHING TO EAT OR DRINK.**

NAME: \_\_\_\_\_ PHONE: (home): \_\_\_\_\_ (work): \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

What Procedure is planned? \_\_\_\_\_ SURGEON: \_\_\_\_\_ SURGERY DATE: \_\_\_\_\_

YES	NO	Please check the "Yes" or "No" box for each of the following questions. If your answer is "Yes", please circle appropriate response.	
		Have you ever been a patient at Santa Barbara Surgery Center before?	When?
		Have you had previous surgeries?	List:
		Any anesthesia complications?	List:
		Any family with anesthesia problems?	List:
		Any heart problems?	Heart Attack / Angina / Heart Failure / Heart Rhythm Abnormalities
		Neurologic problems?	Fainting / Seizure / Stroke / Headache / Migraines / Myasthenia / MS
		Any heart procedures?	Bypass / Valve Replacement / Angioplasty / Coronary Stent / Defibrillator
		Dates of heart problems / procedures?	
		Blood pressure problem?	High / Low Are you taking medications?
		Respiratory problems?	Pneumonia / Emphysema / Nighttime Dry Cough / Bronchitis / Asthma Rhinitis / Wheezing during exercise / wheezing more than 3x in the last 12 mo. / Shortness of Breath
		Do you have sleep apnea?	Use Oxygen at Night / Use Positive Pressure Device (CPAP)
		Do you smoke?	How much? When did you quit?
		Infectious disease?	Cold / Flu / Cough / Fever / History of Tuberculosis
		Diabetes?	List medications:
		Kidney or bladder problems?	Kidney failure / Dialysis / Stones / Infections Do you take flomax?
		Liver disease?	Jaundice / Hepatitis / Cirrhosis / Liver Failure
		Gastrointestinal problems?	Ulcer / Hiatal hernia / Reflux / Gastritis
		Have you had cancer?	Type: When?
		Pain/Mental/Physical problems?	Where? Walking / Back Pain / Neck Pain / Depression / Other

# 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.	
		<b>Blood or bleeding problems?</b>	Anemia / Poor blood clotting / Too much clotting / Deep Vein Thrombosis
		<b>Do you use aspirin or blood thinners?</b>	Last use:
		<b>Thyroid problems?</b>	Hyperthyroid / Hypothyroid
		<b>Dental or jaw problems?</b>	Dentures / Caps / Loose teeth / TMJ / Trouble opening mouth
		<b>Vision problems?</b>	Glaucoma / Cataract / Eyeglasses / Contacts / Blindness
		<b>Hearing / Language needs?</b>	Hearing Aid / Deafness / Interpreter needed
		<b>Do you use alcohol?</b>	How much?
		<b>Do you use herbal remedies?</b>	Type:
		<b>Do you use recreational drugs?</b>	Type:
		<b>Would you accept blood in a life threatening emergency?</b>	
		<b>Any possibility of pregnancy?</b>	

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!**

