Spivey Station Surgery Center

Please fill out this health questionnaire as accurately as possible ***and bring it with you to our facility***.

1. How tall are you?________________________ What is your current weight?_____________________
2. **Women:** When was your last menstrual cycle? __________________(*please indicate if you have had a medical procedure that prevents pregnancy)*____
3. List all medications that you take, including over the counter medicines, herbs, and dietary supplements.____
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4. Do you take any prescription blood thinners, or over the counter medications such as ASA, Ibuprofen, Advil, Aleve, etc.? If yes, how often, and when was your last dose? ______________________________
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(If you are uncertain that the medication you take is a blood thinning product, PLEASE CONTACT YOUR PHARMACY OR PHYSICIAN PRIOR TO YOUR ARRIVAL.)

5. List all past and present medical History:

__High Blood Pressure	__Seizures	__Stroke or TIA	__Neurological Disorder
__Acid Reflux	__Peptic Ulcer	__Seasonal Allergies	__Diabetes
__Heart Condition	__Heart Attack	__Irregular Pulse	__Asthma
__Breathing Difficulties	__Lung Disease	__COPD	__Sleep Apnea
__Kidney Disease	__Liver Disease	__Skin Disorder	__Blood Disorder
__Communicable Disease	__Cancer	__Any other past or present medical conditions	

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6. List all surgeries that you have had in the past.____
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7. Have you, or any blood-related family ever experienced difficulties with anesthesia? If yes, explain.
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8. Do you smoke? If yes, how often, and how many years? ______________________________________
9. Do you have anything removable in your mouth? *(dentures, partials, retainers, etc.)*_______________
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10. Do you wear contacts or glasses? ____
11. List all allergies and type of reaction experienced.____
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Signature of the person completing this questionnaire____