

**Oklahoma Hand Surgery Center, Inc.**



**PATIENT QUESTIONNAIRE**

**Have you had OR do you have**

- |   |     |    |
|---|-----|----|
| High blood pressure .....                 | Yes | No |
| Heart attack .....                        | Yes | No |
| Chest pain (angina) .....                 | Yes | No |
| Fast or skipped heart beats .....         | Yes | No |
| Fainting or blackout spells .....         | Yes | No |
| Asthma .....                              | Yes | No |
| Emphysema, bronchitis .....               | Yes | No |
| Shortness of breath .....                 | Yes | No |
| Seizures or stroke .....                  | Yes | No |
| Paralysis or numbness .....               | Yes | No |
| Hepatitis or jaundice .....               | Yes | No |
| Kidney disease .....                      | Yes | No |
| Heartburn or hiatal hernia (reflux) ..... | Yes | No |
| Back or neck injuries .....               | Yes | No |
| Glaucoma .....                            | Yes | No |
| Diabetes .....                            | Yes | No |
| Anemia or bleeding problems .....         | Yes | No |
| Muscle disease or weakness .....          | Yes | No |
| Thyroid disease .....                     | Yes | No |
| Arthritis .....                           | Yes | No |
| Loose or cracked teeth .....              | Yes | No |
| Dentures or caps .....                    | Yes | No |
| Lens implants or contact lenses .....     | Yes | No |
| A positive AIDS blood test .....          | Yes | No |
| Psychiatric or mental disorders .....     | Yes | No |
| Motion sickness .....                     | Yes | No |
| Abnormal reaction to anesthetic .....     | Yes | No |
| Sleep Apnea .....                         | Yes | No |
| Other _____                               |     |    |

**Do You**

1. Smoke? (pkg/day \_\_\_\_\_) ..... Yes No
2. Use alcoholic beverages: ..... Yes No
3. Use drugs not prescribed by a doctor? (cocaine, heroin, etc.) ..... Yes No
4. Object to blood transfusion if needed to save your life? ..... Yes No
5. Have any body piercing? ..... Yes No  
(tongue, belly button, etc.)

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**List previous surgeries**

Type	Date
_____	
_____	
_____	
_____	
_____	

**List medications you are presently taking**

(prescription and over-the counter medications or herbal preparations)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**List allergies (drug, sulfite sensitivity, other)**

_____
_____
_____
_____

\_\_\_\_\_  
**Patient's signature**