Balanced Care for Women of St. Louis, P.C.
10806 Olive Boulevard
Creve Coeur, MO 63141
(314) 993-7009

PRE-OP QUESTIONNAIRE

Name: ______________________________ Age: _______

Date of Surgery: ____________________ Procedure: ______________________________

Please answer all questions. If a question does not apply to you please put N/A.

*******Drug Allergies:** ______________________________

****

Reasons for surgery:

What are your symptoms? ______________________________

When did they first occur? ______________________________

makes them better? ______________________________

What makes them worse? ______________________________

If bleeding is a problem, how often do you change a pad or tampon in a day? ____________

Are you anemic? Y N If so, are you on iron? Y N

What **medical** illnesses do you have? (i.e. asthma, heart disease) ______________________________

____

Do you have AIDS (HIV) or hepatitis B or C? Y N ______________________________

Do you have mitral valve prolapse? Y N If yes, do you get antibiotics before dental work or surgery? Y N

Do you have any seizures or neurological disorders? Y N ______________________________

Who is your primary care doctor? ______________________________

Have you seen him or her lately? Y N __________ Have you gotten medical clearance from him or her? Y N

Medications that you take daily: ______________________________

____

Do you take aspirin or Motrin? Y N How often? ______________________________

Revised 5/04

Copyright © 2008, Balanced Care for Women of St. Louis, P.C.

Balanced Care for Women

Habits: Smoking? Y N Packs per day _______ x _______ years.
Drink alcohol daily? Y N Number of drinks per day __________
Do you use: Marijuana? Y N Cocaine? Y N Amphetamines? Y N

OB History: #____Pregnancies #____Vaginal Deliveries #____C-sections #____Miscarriages

Birth control method: ____

Do you have any psychiatric or psychological illnesses for which you take medicine? Y N
If yes, what? ____

Previous Surgeries:

Year	Type of Surgery	Findings	Complications

Have you ever had nausea after anesthesia? Y N

Do you have trouble clotting your blood? Y N

Do you want to bank your own blood? Y N (rarely necessary)

Have you ever had a blood clot in your leg or lung? Y N

Do you do heavy lifting at work (greater than 20 pounds)? Y N

Have you discussed how long you will be off work for recovery? Y N

Have you planned for your post-operative care at home? Y N

Have we explained the proposed surgery, the risks, and treatment alternatives to your satisfaction? Y N

Do you have additional questions about your surgery? Y N ______________________________

____

The above statements are true to the best of my knowledge and recollection.

____ ____________________

Signature of Patient (or Legal Guardian) Date

Balanced Care for Women™

Copyright © 2008, Balanced Care for Women of St. Louis, P.C.