## *NORTHEAST ALABAMA SURGICAL ASSOCIATES*

***Patient Questionnaire***

**Name: ________________________________ Age: _____ Sex: ☐ Male ☐ Female**

**Height: ______________ Weight: ____________ Dominant Hand: ☐ Right ☐ Left**

**Name of physician who referred you: ________________________________________**

**Name of your Primary Care Physician: ________________________________________**

**Name of your Cardiologist : ________________________________________________**

**Why are you seeing the surgeon today? ______________________________________**

---

**Please Circle Yes or No in answer to the following questions.**

*****If there are multiple options, please <u>circle</u> what applies to you.*****

| Question | | |
|---|---|---|
| Have you ever had a stroke or TIA? | Yes | No |
| Have you ever had epilepsy, blackouts or seizures? | Yes | No |
| Do you have numbness or weakness in your arms or legs? | Yes | No |
| Have you had any weight loss or poor appetite? | Yes | No |
| Have you had any fever, chills or “night sweats”? | Yes | No |
| Have you ever had a heart attack? | Yes | No |
| Have you ever had heart trouble or a “heart cath” study? | Yes | No |
| Have you ever had a heart stent or coronary bypass surgery? | Yes | No |
| Have you ever had fluid in your lungs? | Yes | No |
| Do you have high blood pressure? | Yes | No |
| Have you ever been treated for an irregular heartbeat? | Yes | No |
| Do you ever have chest pain, angina or chest tightness? | Yes | No |
| Do you ever have difficulty breathing? | Yes | No |
| Do you have asthma, bronchitis, or emphysema? | Yes | No |
| Does climbing one flight of stairs make you short of breath? | Yes | No |
| Does walking make your legs hurt? | Yes | No |
| Do you smoke, vape, or use other tobacco products? | Yes | No |
| Have you had liver disease, jaundice, or a history of hepatitis? | Yes | No |
| Do you drink more than 3 drinks of alcohol in a week? | Yes | No |
| Do you have indigestion, heart burn, reflux or hiatus hernia? | Yes | No |
| Have you had stomach ulcers or intestinal bleeding? | Yes | No |
| Do you have pain during or after eating? | Yes | No |
| Do you have a history of thyroid problems? | Yes | No |
| Do you have a history of diabetes? | Yes | No |
| Do you have a history of kidney problems? | Yes | No |
| Do you have problems with blood clots or excessive bleeding? | Yes | No |
| Do you have arthritis, or pain in your neck or back? | Yes | No |
| Do you have any non-healing or slowly healing wounds? | Yes | No |
| Do you use a wheelchair, crutch or cane? | Yes | No |
| Have you or a family member had a reaction to anesthetics? | Yes | No |
| Do you think you may be pregnant? | Yes | No |
| Have you ever had cancer? | Yes | No |
| Have you ever had problems during or after an operation? | Yes | No |

**Please Sign Here:______________________________ Today’s Date: ____________________**