DAVID M. GUTMAN M.D., F.A.C.G.
PROGRESSIVE GASTROENTEROLOGY

Reflux Center of Long Island
Center for Irritable Bowel Syndrome
Fellow of the American College of Gastroenterology
Faculty Lecturer, Mount Sinai School of Medicine

Anesthesia Department

Pre-Surgical Patient Questionnaire

PLEASE FILL OUT AND BRING WITH YOU ON TESTING DAY

NAME: DATE:

1. What is the procedure you are having today?

2. Any major illnesses other than childhood diseases?

3. Have you ever had an operation? If so, please list them and the dates of surgery, if known

4. Please write in any medications, injections or pills that you take (this includes prescription drugs, over-the-counter drugs and vitamins)

You may attach a printed list if you prefer

5. Do you have any allergies to specific medications? If so, please list them

- ☐ No Allergies
- ☐ No Prior reaction to Anesthesia
- ☐ No Blood Relative has had Reaction to Anesthesia

6. Weight______________________ Height_______________________

7. **FEMALES:** If you are under 55 and have had a period within the past year, you will be asked for a urine sample.

8. Date of last menstrual period: _______ How many pregnancies have you had? ____

How many children have you had? _____ How many miscarriages or abortions? _____

9. Is it possible you may be pregnant? _____________

(516) 739-4604
Fax: 280-7482

200 Old Country Road, Suite 520
Mineola, NY 11501

care@progressivegi.com
www.ProgressiveGI.com

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NAME: DATE:

Yes	No	
		1. Any problems with your blood pressure, heart or circulation? (include history of chest pain associated with the use of nitroglycerin)
		2. Any lung disease (eg. Bronchial asthma, emphysema), recent cough, cold or sore throat?
		3. Any seizures, strokes, convulsions, blackouts, fainting spells, headaches?
		4. Any disease of stomach/ intestines
		5. Any disease of liver, jaundice, hepatitis, transfusion reaction?
		6. Any bleeding disorder or bleeding tendency?
		7. Kidney or bladder disease?
		8. Diabetes or thyroid disease? (please circle which applies)
		9. Do you have loose, false, chipped, capped, or bad teeth, bridges or dentures?
		10. Do you wear contact lenses?
		11. Have you taken cortisone by mouth in the past 12 months?
		12. Have you taken nerve pills or tranquilizers in the past 2 weeks?
		13. Do you have more than 2 alcoholic drinks per day?
		14. Do you or have you ever smoked?
		15. If yes, how much? If stopped, when?

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