Island Reproductive Services
www.islandreproductive.com
Eric Knochenhauer, MD
Michael Traub, MD

237 Richmond Valley Road
Staten Island, NY 10309
Phone (718) 948-6100
Fax (718) 948-6114

3000 Hadley Road
South Plainfield, NJ 07080
Phone (908) 412-9909
Fax (908) 412-9910

Pre-Op Medical Questionnaire

Please print all information:

Patient Name: _____ Age: _____

Height: _____ Weight: _____

1. List all operations you have had under anesthesia (including tooth extractions and tonsillectomy). Also, please describe any problems that might occurred with each. Include dates.
   _____
   _____
2. Have you or any family members ever had a serious problem with anesthesia? If YES, please describe.
   _____
3. Have you ever been hospitalized? If YES, please describe._____
   _____
4. List any medical problems or illnesses. _____
5. List all allergies and describe the reaction. _____
   _____
6. Are you allergic to soybeans or eggs? _____
7. List all prescription and "over the counter" medications (aspirin, Tylenol, vitamins) you have taken in the last 3 months. **If you are taking any prescription please bring them with you the day of the procedure.**
   _____
   _____
8. Are you on a special "diet"? If YES, please describe. _____
9. Do you smoke? _____ If YES, how long? _____ How much per day? _____
10. Do you drink alcoholic beverages? _____ If YES, how much? _____

11. Do you have any of the following: ☐ Contact lenses ☐ Capped teeth
☐ Loose or chipped teeth ☐ Braces

12. Have you ever had mental or emotional condition which required medications? If YES, please describe.
_____

13. Have you ever had a blood transfusion? If YES, did you have any reaction to it? If so, please describe.
_____

14. Have you ever had problems with the following:

☐ Chest pain or exertion	☐ Asthma	☐ Diabetes
☐ Chest pain at rest	☐ Difficulty Breathing	☐ Seizures
☐ Heart attack	☐ Shortness of breath	☐ Jaundice or Hepatitis
☐ High blood pressure	☐ Abnormal chest X-rays	☐ Ulcers
☐ Heart murmur		☐ Glaucoma
☐ Anemia		☐ Fainting
☐ Bleeding Problems		☐ Urinary Retention

If YES to any of the above, please describe. _____

_____

_____

15. Do you experience "heartburn"? ☐ Yes ☐ NO Do you snore? ☐ Yes ☐ NO

Take all the medication you normally take except any medication with ibuprofen. If you take medication on a regular basis for a medical condition, please continue taking that medication.

*****IMPORTANT***** If you normally take your routine medication in the morning, please do so the morning before your procedure with a sip of water when you first awaken.

If you have a history of "reflux disease" (indigestion) and take medication for that condition, it is very important to continue the medication. If you have reflux and do not take anything routinely for it, the anesthesiologist is requesting that you take 2 tablets of Prevacid (or other over the counter brand tablet to suppress gastric secretions) the evening before your procedure and then also take 2 tablets the morning of your procedure.

If you have a history of asthma or other respiratory condition and use an inhaler, please **BRING** your inhaler with you the day of the procedure. If you have a history of diabetes, please bring your blood sugar monitor with you.

Signature Date