Feldman-Rayfield Cosmetic Surgery, P.A.
222 New Road, Suite 6
Linwood, New Jersey 08221
609-601-1000 • (Fax) 609-601-1010

PATIENT HEALTH QUESTIONNAIRE

Name:_____ Telephone: Home (____) _____ Work (____) _____

Cell (____) _____ E-Mail: _____

Address:_____ City:_____ State:_____ Zip:_____

Physician: _____ Primary Care Physician: _____ Cardiologist: _____

Procedure: _____ Date of Procedure: _____

Age: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female Height_____ Weight_____

List your current medications, including prescriptions, over-the-counter and herbals:

Med	Dose	Med	Dose

Allergies (include food and latex):

Previous operations:

Do you have or have you ever had a history of:

Y ☐ N ☐ A problem with anesthesia other than nausea and vomiting	**Y ☐ N ☐** Short of breath when you walk up a flight of stairs
Y ☐ N ☐ Has any family member ever had a serious, life-threatening problem with anesthesia	**Y ☐ N ☐** Emphysema
	Y ☐ N ☐ Do you use oxygen at home
Y ☐ N ☐ History of difficult intubation	**Y ☐ N ☐** Diabetes
Y ☐ N ☐ Hiatal hernia or acid reflux	**Y ☐ N ☐** Thyroid problems
Y ☐ N ☐ Sleep apnea **Y ☐ N ☐** If yes, are you on CPAP	**Y ☐ N ☐** Kidney disease/dialysis
Y ☐ N ☐ Dentures, caps, bridgework or braces	**Y ☐ N ☐** Back or neck problems
Y ☐ N ☐ Chipped, or loose teeth	**Y ☐ N ☐** Arthritis
Y ☐ N ☐ High Blood Pressure	**Y ☐ N ☐** Stroke or seizures
Y ☐ N ☐ Do you take blood thinners	**Y ☐ N ☐** Mental illness of any type
Y ☐ N ☐ Angina, chest pain	**Y ☐ N ☐** Do you drink alcohol
Y ☐ N ☐ Rapid or irregular heart beat	If so, how much and how often _____
Y ☐ N ☐ Heart murmur or Valve Disease	**Y ☐ N ☐** Smoke If yes, how many packs per day and for how many years _____
Y ☐ N ☐ Heart attack/Heart Failure	
If so, when Date: _____	**Y ☐ N ☐** Do you use any recreational drugs
Y ☐ N ☐ Coronary Stent/Angioplasty	Please list:_____
Y ☐ N ☐ Pacemaker/Defibrillator	**Y ☐ N ☐** Anemia
Y ☐ N ☐ (EKG) Electrocardiogram	**Y ☐ N ☐** Bleeding disorder/or blood disease
If so, when Date: _____	**Y ☐ N ☐** Hepatitis or liver disease If so, when Date:_____
Where:_____	**Y ☐ N ☐** Female Patients: Could you be pregnant
Y ☐ N ☐ Asthma Last episode Date: _____	**Y ☐ N ☐** History of cancer

IF YOU RECEIVE ANY TYPE OF ANESTHESIA OR SEDATION, YOU MAY NOT OPERATE A MOTOR VEHICLE, AND WILL BE REQUIRED TO HAVE A RESPONSIBLE INDIVIDUAL ESCORT YOU HOME FOLLOWING YOUR PROCEDURE.

Person who will take you home: _____ Phone: (____) _____

Signature: _____ Date: _____

☐ **Parent** ☐ **Guardian**