St. Charles Hospital
Catholic Health Services
At the heart of health

Pre surgical Testing Patient Questionnaire

Please fill out form below. Fax the completed form to 476-5594 prior to your appointment if possible.
If unable to fax ***you must*** bring the completed form with you to your PST appointment.

Name _____ **DOB**_____ **Date of surgery**_____

Surgical Procedure you are having done_____

Primary care physician: _____**Phone #**_____

Cardiologist : _____**Phone #**_____

Have you had the following testing completed within the last 3 years? *If so please indicate where:*

Echocardiogram: _____ Stress Test:_____ Carotid Doppler_____

Cardiac Catheterization_____ Cat Scan _____Chest X-ray (within a year)_____

Allergies (name and reaction)_____

Past medical History: *Please circle*

Diabeties Hypertension High Cholesterol Hypo/Hyperthyroid Heart Disease Hepatitis/Cirrhosis

Seizures Stroke Kidney Disease Bleeding Disorders Cancer COPD

Heart Attack Cardiac Stents/Bypass Surgery Sleep Apnea Bariatric Surgery Clotting Disorder

Other:_____

Implanted devices (pacemaker, insulin pump, nerve stimulator) manufacturer/model #_____

Medication list: *please list all prescription and over the counter medications taken within the last month (you may attach additional page if necessary)*

Name	Dose	Time Taken	Reason

Do you live alone? YES/ NO Is someone dependent upon you for their care? YES/NO

Do you have a support person to assist you after surgery? _____ Name_____

Pharmacy name_____**Phone number**_____

If you have a health care proxy or living will please bring a copy with you to Pre-surgical testing