HVAS Hudson Valley Ambulatory Surgery, LLC
Same Day Surgery Experts
75 Crystal Run Road, Building B, Suite 225, Middletown, NY 10941 T: (845) 692-9900 F: (845) 692-0800

Pre-Surgical Testing Form for _____
Patient Name

Please answer the following questions accurately.
The anesthesiologist will review your answers with you before surgery.

Age____ Height_____ Weight_____ Family physician_____

Describe any chronic health conditions that require you to see your family physician on a regular basis:_____

_____

_____

List the names and dosages of all medications you take on a regular basis:_____

_____

_____

List all operations you have been through, including the year of surgery:_____

_____

_____

Have you had any problems with anesthesia in the past? If yes, please describe:_____

_____

_____

Are you allergic to soybeans, eggs, or any medications? If yes, please list:_____

_____

Allergic Reaction?_____

Have you been hospitalized for any medical conditions?_____

_____

Do you or any family members have a muscular disorder such as muscular dystrophy?_____

_____

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Please place a checkmark in the Yes or No column or write your response on the appropriate line

	Yes	No		Yes	No
Dentures, caps, bridge work, braces or loose teeth			Wear contact lenses		
Anesthesia-related problems in your family			History of drug abuse		
History of high blood pressure			History of chest pain/angina		
Have you had a heart attack/congestive heart failure?			History of palpitations		
History of rheumatic fever			Heart murmur		
Do you have a pacemaker/internal defibrillator?			Recent sore throat or chest cold		
History of leg cramps when walking			Have you been treated for TB?		
Short of breath when you do not sleep on 2 or more pillows			Hiatal hernia		
History of pneumonia, asthma, bronchitis, or emphysema			Treated for anemia		
History of stomach problems, ulcers, or heartburn			History of sickle cell anemia/trait		
History of abnormal bleeding or bruising			Received blood transfusion		
History of kidney failure, stones, or infection			History of thyroid disease		
History of liver disease, hepatitis, or cirrhosis			Do you have diabetes?		
History of arthritis in the jaw, neck, or back			Difficulty opening your mouth		
History of epilepsy or seizures			Do you take birth control pills?		
History of stroke or temporary blackout			Are you pregnant?		
Significant weight loss without dieting in the past 6 months			Date of last menstrual period		
Do you smoke? If yes, how much?			How much alcohol do you drink daily/weekly?		
Pediatric patient: Has your child been sick in the past month?			Do you have sleep apnea?		
Was your child born prematurely?			Do you use a CPAP?		

Is Patient on Anticoagulant/Aspirin/Platelet Therapy?____Yes ____No. Is MD Aware? ____Yes ____No.

Patient to Stop? ____Yes ____No. Length of time to stop therapy _____

Did physician ask patient to stop ? ____Yes ____No.

Patient signature_____ Reviewed by_____ Date_____

Submit Form