Miami SURGICAL Center

PRE-OP QUESTIONNAIRE

DATE:_____

NAME:
_____

DOB: _____ PROCEDURE DATE: _____

DOCTOR:
_____

ALLERGIES:
_____
_____
_____

INDICATE MEDICAL PROBLEMS: Height: _____
Weight:_____

_____ High Blood Pressure
_____ Diabetes
_____ Cardiac Problems
_____ Mitral Valve Prolapse
_____ Glaucoma
_____ Kidney/Liver Problems
_____ Prostate Problems

MEDICATIONS:
_____
_____
_____
_____

OTHER:_____
_____
_____
_____