SURGICAL CANDIDATE QUESTIONAIRE

Patient Name: _____

Date of Birth: _____

SS#: _____

Marital Status: _____

Best Contact #: _____

E-mail address: _____

Weight: _____ **lbs.** **Height: ___ft. ___in.**

*If you have a history of CAD, cardiac stents, heart attack, CHF, cardiomyopathy, pacemaker/AICD, valvular heart disease, drug use or sleep apnea please notify the surgical coordinator.

Please list prescription medications the patient is on: _____

Please list any current medical conditions:_____

Employer: _____

Employer Address: _____

_____

Person Picking Surgical Candidate Up After Surgery: _____

Relationship to Patient: _____ **Phone #:** _____

Address: _____

_____

Primary Care Physician: _____

Office #: _____

Address: _____

_____

Does the surgical candidate have a latex allergy? YES NO