Northern Litho
INCORPORATED
LITHOTRIPSY SERVICE

Patient Questionnaire

PATIENTS NAME: _____ DATE: _____

BIRTH DATE: _____ AGE: _____ SEX: M FE

REFERRING PHYSICIAN: _____

HEIGHT: _____ WEIGHT: _____

PRESENTLY: SMOKE: _____ HOW MANY PACKS A DAY: _____

DRINK ALCOHOL: OCCASIONALLY NEVER DAILY
IF DAILY: HOW MANY A DAY _____

USE RECREATIONAL OR STREET DRUGS: _____

HAVE YOU OR ANYONE IN YOUR FAMILY HAD PROBLEMS WITH ANESTHESIA? _____
WHAT KIND OF PROBLEMS DID YOU HAVE:
_____
_____
_____

CIRCLE ANY POSITIVE CONDITIONS:

HIGH BLOOD PRESSURE LOW BLOOD PRESSURE IRREGULAR HEART BEAT

HEART ATTACH HEART MURMUR HEART FAILURE PROLAPSED MITRAL VALVE
VALVE REPLACEMENT HEART BYPASS HOW MANY: _____ DATE:_____

EMPHYSEMA ASTHMA SHORTNESS OF BREATH CHRONIC BRONCHITIS

KIDNEY STONES BLADDER STONES URINARY TRACT INFECTIONS

STOMACH ULCER HIATAL HERNIA HEPATITIS CHRONIC DIARRHEA

CONSTIPATION COLITIS

BLEEDING DISORDER BRUISE EASILY SICKLE CELL DISEASE OR TRAIT

STROKE SEIZURES MULTIPLE SCLEROSIS EPILEPSY PARKINSONS

DIABETES DIET CONTROLLED (IF YOU MONITOR YOUR SUGAR AT HOME, PLEASE CHECK BEFORE PROCEDURE)

BLOOD SUGAR THIS MORNING:_____ LAST TIME YOU TOOK MEDICATION:_____

GOUT THYROID DISEASE GLAUCOMA ARTHRITIS

OTHER MEDICAL CONDITIONS (NOT COVERED ABOVE):

_____
_____
_____

SURGERIES IN THE PAST:

_____
_____
_____
_____
_____

MEDICATIONS:
PRESCRIPTIONS AND OVER THE COUNTER DRUGS, DOSAGE AND HOW OFTEN:
PLEASE INDICATE MEDICATIONS TAKEN DAY OF PROCEDURE:

_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS: NONE
LIST MEDICATIONS AND TYPE OF REACTION

_____
_____
_____
_____

COMPLETED BY: _____

TO BE COMPLETED BY THE NURSE:

LAST TIME PATENT ATE OR DRANK:_____
DATE OF LAST MENSTRUAL PERIOD:_____ HCG:_____

QUESTIONNAIRE REVIEWED BY:_____

DATE:_____

COMMENTS:
_____
_____
_____
_____