

DINESEN



ASSOCIATES

OBGYN & INFERTILITY

599 W State Street
The Pavilion at Doylestown Hospital
Suite 301
Doylestown, PA 18901

**Patient Questionnaire
Pre-Operative**

Name: _____

Date of Birth: _____

Date of Surgery: _____

Procedure: _____

Current Insurance carrier: _____

ID #: _____

Please list ALL current prescription medications and DOSAGES

Please list ALL current over the counter medications

Do you have allergies to any medications? YES NO

If yes please list:

Do you have any allergies to Latex? YES NO

If yes please explain what happens: _____

Current Medical problems: _____

Do you smoke? YES NO #packs/day _____

Past Surgeries: _____

Name of Family Physician: _____

Name of Cardiologist: _____

Name of other Specialist: _____

: _____

Signature: _____

Date: ___/___/___