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:** ___/___/_____