MANHATTAN REPRODUCTIVE SURGERY CENTER

65 Broadway, 21st floor
New York, NY 10006
Tel: 212-818-0001 Fax: 212-818-0090

Manhattan Reproductive Surgery Center Pre-Admission Questionnaire

Dear Patient,

This questionnaire will help the Manhattan Reproductive Surgery Center team determine what, if any, preoperative work up will be needed prior to your surgery and help them gather all available medical information about you. Please fill it out as best you can. This information will help to avoid any delay in your surgery. In some cases, we will contact you to schedule an appointment for a preoperative anesthesia evaluation at our center.

If you have any questions, please contact us at **(212) 818-0001.**

Patient Information: *Please Print and Answer All Questions*			
Patient Name:	DOB:	Height:	Weight:
Street Address:	City:	State:	Zip Code:
Email:	Cell #:	Home #	Work#
Date of Surgery:	Surgeon:	Procedure:	
Primary Medical Doctor Name:		Primary Medical Doctor Phone #:	
Best Time to Reach You (circle which one):		AM or PM	
Best Method to Reach You: (circle which one):		Cell# Home# Work # Email	
Emergency Contact:			
Last Name:	First Name:	Relationship:	
Cell #:	Home #:	Email:	

Part 1: Have you had any of the following symptoms or illness? (Yes or NO)		**Yes**	**No**
1. Heart?			
a.	High Blood Pressure		
b.	Heaviness, tightness or pain in your chest during or after physical activity?		
c.	Heart Attack? If YES, when? _____		
d.	Birth defect involving the heart?		
e.	Infection involving the heart? (Rheumatic fever or Endocarditis)		
f.	Heart Murmur?		
g.	Irregular heartbeat?		
h.	Swelling in the ankles or fluids in the lungs?		

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i.	Pain in your legs when waking?		
j.	Previous heart operations? If YES, when? _____		
k.	Pacemaker? If YES, when? _____		
l.	Other kinds of heart problems? Please describe: _____		
m.	Did you ever have any heart studies? (echocardiogram, stress test, catherization) If YES, please specify which study and when? _____		
2.	**Lung?**		
a.	Asthma?		
b.	Sleep apnea?		
c.	Do you use a CPAP Machine? If YES, please provide Pulmonary Doctor's contact information: _____		
d.	Bronchitis?		
e.	Smoking related lung disease?		
f.	Pneumonia? If YES, when? _____		
g.	Tuberculosis? If YES, when? _____		
h.	Awakening from sleep feeling shortness of breath? Chest X-RAY that was NOT normal?		
i.	Chest X-RAY that was NOT normal?		
j.	Have you previously tested positive for COVID-19? If YES, when? _____		
3.	**Circulation?**		
a.	Anemia?		
b.	Sickle Cell Disease or trait?		
c.	Bleeding Tendency or Easy Bruising?		
d.	Blood Clot in your legs or lungs?		
e.	Previous Blood Transfusion?		
4.	**Metabolism?**		
a.	Diabetes? (Sugar in Urine)		
b.	High Cholesterol?		
c.	Problems with your Thyroid Gland?		
5.	**Digestive System?**		
a.	Frequent heart burn?		
b.	Ulcer?		
c.	Jaundice?		
d.	Hepatitis?		
b.	Cirrhosis?		
6.	**Nervous System?**		
a.	Frequent Headaches?		

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b.	Dizzy Spells?		
c.	Loss of Balance?		
d.	Difficulty speaking or Slurring of Speech?		
e.	Fainting Spells?		
f.	Loss of feeling or strength in any part of your body?		
g.	Stroke? Or "Mini"-Stroke? If YES, when? _____		
h.	Convulsions, Seizures, or "Fits"?		
i.	Mental or Nervous Disorder?		
7.	**Musculoskeletal System?**		
a.	Shooting Pains in your Arms or Legs?		
b.	Numbness or Tingling (Pins and Needles) in any part of your body? If YES, please describe where: _____		
c.	Rheumatoid Arthritis?		
d.	Herniated Disc in the Neck or Back?		
8.	**Reproductive System?** *(Applies to Women only)*		
a.	When was your last menstrual period? _____		
b.	Are you Pregnant?		
9.	**Teeth?**		
a.	Do you have artificial (false) teeth?		
b.	If YES, *please circle all that apply*:		

Upper Denture	Partial	Full
Lower Denture	Partial	Full
Bridge	Upper	Lower

C.	Do you have any Loose Teeth? If YES, where? _____		
10.	**Social Habits?**		
a.	Have you ever smoked?		
b.	If YES, What do you smoke? _____ When did you start smoking? _____ How much on average do you smoke per day? _____ Have you stopped? If YES, when? _____		
c.	Do you drink alcohol?		
d.	If YES, How often do you drink? _____		

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How much do you drink? _____		

Part 2: Hospitalizations & Medications

1. Previous Hospitalizations, Surgeries, and/or Procedures:

Date:	Reason for hospitalizations
A.	
B.	
C.	
D.	

2. Medications Presently Taken (Include Non-Prescription Medications):

Name:	Dosage:	Frequency:
A.		
B.		
C.		
D.		
E.		
F.		
G.		

Part 3: Allergic Reactions

1. Have you ever had an allergic reaction to food, medication, or latex?	Yes or No			
If you answered YES to #1, please list allergies and describe the reaction (*please circle all that apply*):				
A.	Rash	Hives	Swelling	Difficulty Breathing
B.	Rash	Hives	Swelling	Difficulty Breathing
C.	Rash	Hives	Swelling	Difficulty Breathing
D.	Rash	Hives	Swelling	Difficulty Breathing
2. Have you ever had Anesthesia for any reason in the past?	Yes or No			
If you answered YES to #2, (*please circle all that apply*):				
A. What type of anesthesia were you given?	General	Spinal	Epidural	Local
B. Did you ever experience a problem with anesthesia?	Yes or No			
1. If YES, please describe the problem:	_____ _____			

3. Do you or any member of your family have a history of (*Please check all that apply*):

- ☐ Malignant Hyperthermia
- ☐ Muscle or neuromuscular disorder

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- ☐ High temperature following exercise
- ☐ History of muscle spasm
- ☐ Dark or chocolate colored urine
- ☐ Unanticipated fever immediately following anesthesia
- ☐ Unanticipated fever immediately following serious exercise

Person completing form: _____ Date: _____