MEDICUS	**PRE-SURGERY EVALUATION SERVICE -** **SELF QUESTIONARE**	PR-PQUI-01-F01 Rev. 00 29/04/2019

Name and Surname:		Age:
Surgical intervention:	Date of the surgical procedure:	Name of Physician who will take this report:
MEDICATION that you take (including Homeopathic Preparations, etc.):		

Are you currently having or did you have any of these health problems?	**YES**	**NO**	**Explanations**
1) Do you do exercise regularly?			
2) Do you smoke?			How many a day?:
3) Do you drink alcohol?			
4) Do you do drugs (Marihuana, Cocaine, Methamphetamine)?			
5) Are you allergic to DRUGS, dust, pollen, and mite?			Add more info:
6) In the last 10 years, did you receive the TETANUS VACCINE?			Date:
7) Do you have High Blood Pressure? Are you under treatment?			
8) Stroke?			Date:
9) Diabetes or high sugar in blood? Are you under treatment?			
10) Cholesterol or Triglycerides high in blood? Are you under treatment?			
11) Arrhythmia?			
12) Any illnesses in the Heart Valves (Valvular Heart Disease)?			More info:
13) Do you have pain in the chest diagnosed by a Cardiologist, Medical Physician?			
14) Myocardial Infarction or Heart Attack?			Date:
15) Heart Surgery, Angioplasty, Coronary Stent or Coronary Bypass?			Date:
16) Do you snore at night or stop breathing normally?			
17) Do you have Asthma?			

18) Emphysema?			
19) Chronic Obstructive Pulmonary Disease (COPD)?			
20) Low blood count? Anemia?			
21) Other blood related illnesses (Leukaemia, Lymphoma)?			More info:
22) Do your gums bleed every day when you brush your teeth?			
23) Internal bleeding problems (Digestive tract, Gynecology)?			
24) Coagulation Disorders (Hemophilia, von Willebrand's Disease)?			More info:
25) Do you have bruises normally without hurting yourself?			
26) Do you take Pills for Blood Clotting?			
27) Do you take an Aspirin a day to prevent a Heart Attack or Stroke?			
28) Have you ever received a Blood Transfusion?			
29) Liver or Gallbladder Disorders (Hepatitis, Fatty Liver, Liverstones)?			
30) Current or past Infectious Diseases?			More info:
31) Thyroid Diseases (Hypothyroidism, Nodules, Cancer)?			
32) Seizures or Epilepsy?			
33) Depression or other Psychiatric Disorders? Are you under treatment?			More info:
34) High Eye Pressure or Glaucoma?			
35) Have you ever been Hospitalized? Why?			More info:
36) Have you ever had any Surgical Procedure (Surgery, Endoscopy)?			More info:
37) Have you ever had any problems with Anaesthesia?			More info:
38) Do you use Birth Control Methods (Condom, Pills, IUD)?			More info:
39) Date or Age of the last time you had your period (in case of Menopause)			More info:
40) Are you a Jehovah's Witness (in case of blood transfusion)?			

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Para ser completado por el Enfermero o Técnico en Cardiología ***(To be completed by the Nurse or Technician Cardiology)***	
• Tensión Arterial *(Blood Pressure)*	
• Peso *(Weight)*	
• Talla *(Height)*	
• Frecuencia cardíaca *(Heart Rate (Pulse))*	

	NO REALIZADO *(Not executed)*	REALIZADO *(Executed)*	
Electrocardiograma (ECG) *(Electrocardiogram)*			**Fecha**: / / *(Date)*

Firma y Sello del Enfermero / Técnico en Cardiología
(Signature and stamp Nurse / Technician Cardiology)