MEXICALI BARIATRIC CENTER TOLL FREE (888) 344-3916 Ave. Madero# 1119-2
www.mexicalibariatric.com FROM USA (619) 817-8181 Centro Mexicali, B.C
ninaeguiambc@gmail.com DIRECT (619) 917-9028 Mexico 21100

Pre-Surgery Questionnaire

Procedure:

If you have additional information that is important for the doctor know, please add on to this form.

YOUR SAFETY DEPENDS ON THE ACCURACY OF THE INFORMATION THAT YOU PROVIDE.

*Name: *Height: *Age:
Email: *Weight: *BMI:
Address: City:

State: Zip:

*Telephone: Cell: Max Weight: When?
Home:

*Allergic to: Birth Date:
Surgery Date:
*Emergency Contact: Phone:

*Any medical/physical problems (i.e., sleep apnea, high blood pressure, diabetes, high cholesterol, blood diseases, neurological disorders, etc.)? ☐ Yes ☐ No ☐ Do Not Know
If yes, please list:

Are you currently taking any medications or herbal supplements? ☐ Yes ☐ No
If yes, please list the name, dosage and reason for taking this medicine):

Is there are history in your family of diabetes, cancer and/or hypertension? ☐ Yes ☐ No ☐ Do Not Know
If Yes, please indicate which:

Any surgeries (i.e., gallbladder, appendix, hernia, heart, etc.)? ☐ Yes ☐ No ☐ Do Not Know
If Yes, please list:

Do you have any adverse reaction to anesthesia? ☐ Yes ☐ No ☐ Do Not Know
If Yes, please indicate reaction:

Do you have dentures, dental implants, or caps? ☐ Yes ☐ No
If Yes, please indicate where:

Do you have any children? If so, how many? ☐ Yes ☐ No

Do you have heavy periods? ☐ Yes ☐ No

Do you smoke? If so, how many a day? ☐ Yes ☐ No

Do you drink? If so, how many a day? ☐ Yes ☐ No

Do you do drugs? If so, what kind & how often? ☐ Yes ☐ No

MEXICALI BARIATRIC CENTER TOLL FREE (888) 344-3916 Ave. Madero# 1119-2
www.mexicalibariatric.com FROM USA (619) 817-8181 Centro Mexicali, B.C
ninaeguiambc@gmail.com DIRECT (619) 917-9028 Mexico 21100

Pre-Operative Assessment

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

For the Following Questions, Please Indicate "Yes" "No" or "Do Not Know". ***Please answer all of the questions.***

Do you currently take any of the following medications?

a) Aspirin (excedrin, anacin, bufferin)	☐ Yes	☐ No	☐ Do Not Know
b) Anticoagulants (blood-thinning medicine)	☐ Yes	☐ No	☐ Do Not Know
c) Propanol, Verapamil (heart rhythm medicines)	☐ Yes	☐ No	☐ Do Not Know
d) Diuretics (water pills)	☐ Yes	☐ No	☐ Do Not Know
e) Antihypertensive drugs (blood pressure pills)	☐ Yes	☐ No	☐ Do Not Know
f) Digitalis (heart pills)	☐ Yes	☐ No	☐ Do Not Know
g) Stereoids (prednisone, cortisone)	☐ Yes	☐ No	☐ Do Not Know

Have you ever been treated for cancer with chemotherapy or radiation therapy?
If yes: when:_____ ☐ Yes ☐ No ☐ Do Not Know

Do you currently have any problems with your:

a) Liver (e.g. cirrhosis, hepatitis, yellow jaundice)	☐ Yes	☐ No	☐ Do Not Know
b) Kidneys (infection, stones, failure)	☐ Yes	☐ No	☐ Do Not Know
c) Spleen	☐ Yes	☐ No	☐ Do Not Know
d) Blood (anemia, leukemia)	☐ Yes	☐ No	☐ Do Not Know

Have you or anyone in your family ever had a serious bleeding problem? ☐ Yes ☐ No ☐ Do Not Know

Have you ever had prolonged or unusual bleeding from tooth extractions, cut, surgery or nosebleed? ☐ Yes ☐ No ☐ Do Not Know

Do your gums bleed when you brush your teeth? ☐ Yes ☐ No ☐ Do Not Know

Are you pregnant? ☐ Yes ☐ No ☐ Do Not Know

Is there any possibility that you are pregnant? ☐ Yes ☐ No ☐ Do Not Know

Have you been told you have diabetes? ☐ Yes ☐ No ☐ Do Not Know

Do you wake up to urinate more than once at night? ☐ Yes ☐ No ☐ Do Not Know

Do you have muscle cramps or pains? ☐ Yes ☐ No ☐ Do Not Know

Do you have problems with your lungs or chest? (e.g., chest pain, skipped heart beats, high blood pressure, smoke one or more packs a day, shortness of breath, emphysema, asthma, bronchitis) underline all that apply ☐ Yes ☐ No ☐ Do Not Know

Do you have a cough, or cough frequently? ☐ Yes ☐ No ☐ Do Not Know

Do you have epilepsy or suffer from fits or seizures? ☐ Yes ☐ No ☐ Do Not Know

Do you have neck or back problems? ☐ Yes ☐ No ☐ Do Not Know

Are you scheduled to have an operation? (Besides this one) ☐ Yes ☐ No ☐ Do Not Know
If Yes, what operation?

Are you currently taking any medications? If Yes, please list: ☐ Yes ☐ No ☐ Do Not Know