

Pre-Operative Questionnaire

Patient Name: _____

1. Has the patient or any family member had any prior problems with anesthesia?

Yes No

If so, what? _____

2. Has the patient or any family member been diagnosed with a bleeding disorder?

(Example: von Willebrand's disease, Hemophilia)

Yes No

If so, what? _____

3. Does the patient have any chronic medical illness (diabetes, asthma, kidney, heart, etc.)?

Yes No

If so, what? _____

4. Is the patient on any daily chronic medications?

(Example: blood thinners or long-term medications for asthma, heart disease, diabetes, etc.)

Yes No

If so, what? _____

5. Has the patient required antibiotics before surgical procedures for Mitral Valve Prolapse?

Yes No

The physician has reviewed the surgical procedure with me. I have received an information packet regarding the procedure, if available.

Signature of Patient or Guardian

Date