BASC QUESTIONNAIRE

2075 Barkley Blvd. #101
Bellingham, WA 98229

HEALTH STATUS

Surgery date:	Scheduled time:

Patient Name:	Age:	Surgeon:
		Surgical Procedure:

HEAD/EYES/NOSE/ THROAT	No	Yes	RN notes	GENERAL HEALTH	No	Yes	RN notes
Hearing loss?				Headaches/ Migraines? ___			
Vision loss? ___				Weight loss/loss of appetite?			
Glaucoma ___ Cataracts? __				History of drug resistant			
Sinus problems?				organism? (MRSA/ VRE)			
Seasonal allergies?				Ever in hospital isolation?			
TMJ disease/Problems?				Child immunizations			
NEUROLOGICAL				Any other health issues?			
Headaches/ Migraines___				BLOOD DISORDERS			
Seizures?___ Last one? _____				Bleeding problems?			
Stroke? ___ When? _____				Anemia?			
Numbness anywhere?				Immune disorders?			
Muscle disease?				Recent blood transfusion?			
RESPIRATORY				SKIN/LYMPHATICS			
Shortness of breath?				Enlarged glands?			
Recent cold or sore throat?				Rashes?			
Chronic cough?				CANCER			
Asthma?___ episodes/ wk__				What type?			
Emphysema?				When?			
Use inhalers? times/ week__				Treatment?			
Home oxygen?				MUSCULOSKELETAL			
Snoring?__ Sleep apnea? ___				Back or neck problems?			
CARDIOVASCULAR				Arthritis?			
High blood pressure?				Physical limitations? Explain:			
Heart attack?							

Chest pain (angina)?							
Pacemaker/defibrillator?							
Irregular heart rhythm?							
Murmur?				GENITOURINARY			
Phlebitis/blood clots?				Kidney problems?			
Congestive heart failure?				Infections?			
Circulation issues/leg pain?				Prostate problems?			
Heart catheterization/ Stent?				Last menstrual period? _____			
Angioplasty?				Could you be pregnant?			
GASTROINTESTINAL				Birth control method?			
Swallowing problems?				PROSTHESIS/IMPLANT/DEVICES?			
Heart burn/Reflux?				Heart valve?			
Hiatal hernia?				Joint?			
Peptic ulcer disease?				Eyes?			
Hepatitis ___A; ___B; ___C?				Artificial limb?			
ENDOCRINE				Hearing aids?			
Diabetes? How long? _____				Dentures/partials?			
Insulin ___ Oral agent ___				Contact lenses __ Glasses___			
Thyroid disease?				Walker/wheelchair/ cane?			

PREVIOUS SURGERIES/approximate dates		
Problem with anesthesia for you or a family member?		
▫ Yes ▫ No		
ALLERGIES HABITS		REACTIONS
To Medications? ▫ Yes ▫ No		Treatment for drug or alcohol abuse? ▫ Yes ▫ No
		Recreational drug use? ▫ Yes ▫ No If yes, provide further information

		Alcohol? Drinks/day?
		Cigarettes? Per day When quit?
		Caffeine? Cups/day?
Food? ▫ Yes ▫ No		ADVANCE DIRECTIVE
Latex? ▫ Yes ▫ No		▫ Yes ▫ No Located?
Iodine on skin? ▫ Yes ▫ No		
Tape/bandaid? ▫ Yes ▫ No		
Soy? ▫ Yes ▫ No		
Other? ▫ Yes ▫ No		
OTHER INFORMATION		
Family Doctor		Specialist
Patient signature: Date:		
*ADDITIONAL INFORMATION NEEDED TO COMPLETE CHART		
WT: _____ lb. _____kg. HT: _____ BMI _____		Medical records sent for? Date: Time:
Escort's full name:		
Escort's phone: ▫ Call ▫ Here		Test results requested? Date: Time: Lab, EKG, etc.
Overnight care person:		
Phone:		
PREOP INTERVIEW/SPECIAL INSTRUCTIONS:		
▫ NPO		
▫ Patient rights & responsibilities provided		
▫ Special medication instructions		
		Medical records requested? Date _____ time _____
