



50705

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

GENERAL PATIENT INFORMATION: (To be completed by Patient, Guardian or Admitting Nurses)

Name: _____

Fluent in English: Yes No Language Spoken: _____ Translator needed: Yes No

Age: _____ Sex: _____ Date of Birth: _____ / _____ / _____

Surgeon Name: _____ Expected Date of Surgery _____ / _____ / _____

Primary Care Physician: _____

Primary Care Physician's Phone No. (_____) _____

Cardiologists Name _____ Phone No.: (_____) _____

Expected Procedure: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Telephone Number to be Reached Prior to Surgery: _____

Best time to call: Afternoon Evening May we leave a message? Yes No

Do you have allergies? Yes No FOOD DRUG LATEX OTHER _____

ALLERGEN	REACTION

LIST PRIOR SURGERY	DATE	LIST ANY COMPLICATIONS

What previous Anesthesia have you had?

General Regional Spinal Epidural Local None Unsure

Please list any complications/problems experienced with anesthesia.

Please list prior Hospitalizations including Emergency Department visits

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Heart: Do you have or ever had the following:

- 1) Atrial fibrillation or irregular heartbeat?
- 2) High blood pressure or Mitral Valve Prolapse?
- 3) A heart attack, angina, or chest pain?
- 4) A heart murmur, heart failure or heart surgery?
- 5) High cholesterol?
- 6) Chest pain or shortness of breath when climbing a flight of stairs?
- 7) A catheterization of your heart? If so,

Date ___/___/___ Where _____

- 8) A heart stress test? If so,

Date ___/___/___ Where _____

Do you:

- 9) Take antibiotics prior to a surgical procedure or dental work?
 - 10) Do you have a pacemaker or implantable defibrillator (AICD)?
- If yes, manufacturer: (check one)
 Medtronic Guidant St. Jude Biotronik Other
- Date ___/___/___ Where _____

Ask your cardiologist to send the most recent pacemaker interrogation to the surgeon and please bring your information card with you on the day of surgery.

- 11) Are you 60 years old or older?

PATIENT ONLY		CLINICIAN USE ONLY	
No	Yes	Test for "Yes" Answers	Anesthesia Consult *
		EKG	*
		EKG	
		CBC, EKG	*
		CBC, EKG	*
		EKG	*
		CBC, EKG	*
		CBC, EKG	
		If yes, contact EP specialist	
		EKG	

Breathing: Do you have or ever had the following:

- 12) Shortness of breath with exertion or swollen ankles?
- 13) A need for more than one pillow or wake up at night short of breath?
- 14) Tuberculosis (TB)?
- 15) Smoked more than 1 pk/day for 20 yrs or 2 pks/day for 10 yrs?
- 16) Smoked in the last year?
- 17) Oxygen at home to help you breathe?
- 18) Severe emphysema, asthma or bronchitis (COPD) that limits your activities?
- 19) Did you ever have an embolus or clot go to your lung?

		CBC, EKG	*
		CBC, EKG	
		CXR	
		CBC, CXR	
		CBC, CXR	*
		EKG, CXR	*

Obstructive Sleep Apnea (OSA):

- 20) Do you have Obstructive Sleep Apnea (OSA)?
- 21) Do you frequently snore loudly, enough to be heard through closed doors?
- 22) Have you been told by others that you gasp, choke, snort, or stop breathing during your sleep?
- 23) Do you have or are you being treated for high blood pressure?
- 24) Do you use a BiPAP or C-PAP machine at home?
 If so, settings: _____

		CBC, EKG, CXR	*
		CBC, EKG	
		CBC, EKG	*
		EKG	
		CBC, CXR	*

* Anesthesia Consult Recommended
 CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
 LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP



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Blood Disorders: Do you have or ever had the following:

- 25) Anemia or low blood count?
- 26) Bleeding ulcers or rectal bleeding?
- 27) Sickle cell disease or trait?
- 28) Blood clots in your legs (phlebitis) or Deep Vein Thrombosis (DVT)?

Do you:

- 29) Use warfarin (Coumadin) as a blood thinner?
- 30) Bruise easily and/or have a bleeding problem?

PATIENT ONLY		CLINICIAN USE ONLY	
No	Yes	Test for "Yes" Answers	Anesthesia Consult *
		CBC	
		CBC	
		CBC, CXR	
		PT/INR	*
		CBC, PT/INR/APTT	

Endocrine/Renal Disorders: Do you have or ever had the following:

- 31) Diabetes?
- 32) Adrenal or thyroid disease or tumor?
- 33) Kidney disease, kidney failure or are you on dialysis?
- 34) Severe hepatitis, jaundice, cirrhosis or liver failure?
- 35) Do you use diuretics (water pills), digoxin (Lanoxin) or steroids (Prednisone)?

		BMP, EKG	
		BMP	
		BMP, EKG, CBC	
		LIV, PT, INR, APPT	
		BMP, EKG	

Gastrointestinal: Do you have or ever had the following:

- 36) Severe abdominal pain?
- 37) Loss of appetite or unintentional weight loss in the past year?
- 38) Acid reflux?

Neurological/Musculo/Skeletal: Do you have or ever had the following:

- 39) Stroke or seizures?
- 40) Weakness in your arms or legs?
- 41) Head, neck or back injuries?
- 42) Chronic pain?
- 43) "Pins and needles" or loss of sensation in your arms or legs?
- 44) "Collagen disease", Lupus, Rheumatoid arthritis, or Raynaud's disease? .

		BMP, EKG, CBC	

Obstetrics

- 45) Are you or do you believe you might be pregnant?
- Last menstrual cycle _____.
- 46) Have you been pregnant in the last 3 months?

		BHCG	
		If yes to (#45 & #46) a blood specimen must be sent < 72 hours of surgery for T & S and T & C	

Cancer: Do you have or ever had the following:

- 47) Cancer and/or received chemotherapy?
- 48) Have you received radiation therapy?
- 49) An axillary lymph node dissection (under arm): Yes No
- Which side: _____

		CBC	
		CXR, EKG, CBC	

* Anesthesia Consult Recommended

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Anesthesia Related Issues: Have you had:

- 50) Problems with placement of a breathing tube in your windpipe (trachea) for surgery?
- 51) Surgery on your throat, vocal cords or lungs?
- 52) Any bad reactions to anesthesia in you or your relatives?
- 53) A history of Malignant Hyperthermia in you or any of your relatives?
- 54) Do you have trouble opening your mouth or bending your neck forward or backward?
- 55) Are you having Bariatric (weight loss), Vascular or Thoracic Surgery (chest)?

PATIENT ONLY		CLINICIAN USE ONLY	
No	Yes	Test for "Yes" Answers	Anesthesia Consult *
			*
			*
			*
			*
			*
			*
			*

You will see YOUR anesthesiologist on the day of surgery. In addition,

- 56) Do you want to see a screening Anesthesiologist before the day of Surgery?

Communicable Disease: Do you have or ever had the following:

- 57) HERPES AIDS HIV
- 58) Contact within the last month with anyone suspected of having SARS?
- 59) Have you traveled outside of the U.S. in the last month?

If yes, where? _____

Eyes: Do you have or had the following:

- 60) Dry eyes?
- 61) Glaucoma or cataracts?

Behavioral Health

- 62) Have you suffered from anxiety, depression, or a psychiatric disorder?

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Blood Transfusion: Do you have or had the following:

- 63) Blood transfusion in the last 3 months?
- 64) A reaction or allergy to a blood transfusion?
- 65) Did you donate blood for this surgery?
- 66) Did a family member donate blood?

		If yes to (#63) a blood specimen must be sent < 72 hours prior to surgery for T&S and T&C	

* Anesthesia Consult Recommended

CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
 LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

Patient/Guardian Signature _____ Date: ___/___/___ Time: _____ AM/PM

If completed by the RN: _____ RN Date: ___/___/___ Time: _____ AM/PM

Nurses Signature