PRE-OPERATIVE INFORMATION

Patient Label

Last Name: First Name: Middle Initial: Nick Name: ☐ Male ☐ Female

Home Phone: May we leave a message at this phone number? ☐ Yes ☐ No

Cell Phone: May we leave a message at this phone number? ☐ Yes ☐ No

Work Phone: May we leave a message at this phone number? ☐ Yes ☐ No

Phone #:

Who will accompany you on the day of your surgery? Relationship? Phone:

Type of Surgery: ☐ Left or ☐ Right Date of Surgery:

ALLERGIES:

Drugs: Other:

☐ Latex ☐ Bananas ☐ Papaya ☐ Kiwi ☐ Tomatoes ☐ Raw potatoes ☐ Avocados ☐ Chestnuts ☐ Soybeans ☐ Eggs ☐ Shellfish

OTHER ALLERGIES:

Are you taking any of the following anticoagulant/blood thinner medications? (Aspirin, Coumadin, Heparin, Plavix, Celebrex, Vioxx, Ibuprofen, Motrin, Advil, Orudis, Lovenox, Arixtra, Fragmin, Vitamin E, Meloxicam, Diclofenac, etc.)

Do you use any of the following: Herbal Supplements: ☐ Yes ☐ No Eye Drops: ☐ Yes ☐ No Laxatives: ☐ Yes ☐ No

SURGICAL HISTORY: (List most recent first)

Previous Surgeries/Year	Previous Surgeries/Year

Have you or any family members had any problem with past surgeries (Difficult intubation, nausea/vomiting, history of malignant hyperthermia, fever, other complications with anesthesia?

Do you have any medical problems in the following areas?

Head: ☐ Yes ☐ No **Legs:** ☐ Yes ☐ No **Abdomen:** ☐ Yes ☐ No **Neck:** ☐ Yes ☐ No **Arms:** ☐ Yes ☐ No

Explain all Yes Answers:

Approximate date of your last **CHEST XRAY:** Where was it taken:

Were the result normal ☐ or abnormal ☐ Date of last physical exam:

Approximate date of your last **EKG** Where was it done:

Were the result normal ☐ or abnormal ☐ Cardiologist:

Who is your primary care physician? Primary care physician's phone number:

TO BE COMPLETED BY PRE-OP SCREENING NURSE:

Pt. has executed advance directive for health care: ☐ Yes ☐ No

Pt. requests information re: Advance Directive for Health Care: ☐ Yes ☐ No

HT: _____WT: _____BMI:_____B/P: _____P: _____R: _____SPO2: _____Temp: _____

Type of Anesthesia: General_____ Regional Block (axillary, infraclavicular, ankle, wrist, etc.) _____ Local W/MAC: _____

Local W/IV Sedation_____Local_____ General W/Interscalene Block_____ Spinal _____ Other: _____

*See Medication Reconciliation Form for current medications.

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK AND DESCRIBE AS NEED:

NEUROLOGICAL
- ☐ Dizzy spells, motion sickness
- ☐ Frequent headaches, migraines
- ☐ Epilepsy, Seizures
- ☐ CVA, Stroke, TIA
- ☐ Parkinson's disease
- ☐ Alzheimer's disease
- ☐ Head or Spinal Injury or Surgery
- ☐ Myasthenias gravis
- ☐ Paralysis
- ☐ Polio
- ☐ Anxiety or Depression

GASTROINTESTINAL
- ☐ Reflux
- ☐ Hiatal hernia
- ☐ Ulcers
- ☐ Colon Problem
- ☐ Liver disease

GENITO-URINARY
- ☐ Kidney disease, kidney stones
- ☐ Renal failure, dialysis
- ☐ Bladder disease
- ☐ Burning with urination
- ☐ Prostate problems
- ☐ Endometriosis

INTEGUMENTARY
- ☐ Current skin rash
  Location: _____
- ☐ Current Injury to skin
  Location: _____
- ☐ Current treatment by Dermatologist
  Location: _____

VASCULAR
- ☐ PE
- ☐ DUT

EYES/EARS/ORAL
- ☐ Glasses, contact lenses
- ☐ Hearing Aids
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Meniere's disease
- ☐ TMJ
- ☐ Loose teeth, chipped teeth
- ☐ Caps, Crowns, Bridgework
- ☐ Braces
- ☐ Dentures
- ☐ Broken Facial Bones
- ☐ Nose or Jaw Surgery

PULMONARY
- ☐ Lung disease
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ COPD
- ☐ Bronchitis
- ☐ Recent cough or cold
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Snoring, Obstruction

COMMUNICABLE DISEASES
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Cirrhosis
- ☐ HIV positive
- ☐ AIDS
- ☐ Tuberculosis
- ☐ MRSA, draining open wound

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid disorders, goiter

CARDIOVASCULAR/BLOOD DISORDERS
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Mitral valve prolapse
- ☐ Dysrhythmia
- ☐ Aneurysm
- ☐ Chest Pain
- ☐ Angina
- ☐ Heart Attack
- ☐ Cardiac Catheterization
- ☐ Cardiac stents: Drug-eluting or Bare-metal
- ☐ Peripheral Vascular disease
- ☐ Congestive heart failure
- ☐ Peripheral Edema
- ☐ Pacemaker/Defibrillator

MUSCULO-SKELETAL
- ☐ Back or Neck Problems, Including previous surgery, fractures, painful Positions
- ☐ Implants or Artificial Joints
- ☐ Arthritis
- ☐ Bone Infection
- ☐ Gout
- ☐ Osteoporosis

CANCER HX
- ☐ Cancer – Type: _____
- ☐ Leukemia

PLEASE ANSWER THE FOLLOWING QUESTIONS THROUGHLY:

1. When you climb two fights of stairs nonstop, do you have shortness of breath? _____ Do you have chest pain? _____
2. If you have high blood pressure, when were you diagnosed with high blood pressure? _____
3. What medications are you taking to treat high blood pressure? _____
4. Do you currently smoke? _____ Amount/Day_____
5. Have you ever smoked in the past? _____ Amount/Day: _____ For how many years? _____
6. Do you exercise? _____ Type of activity? _____ How Often? _____
7. Do you have a sleep disorder? _____ Sleep Apnea? _____ or use a C-Pap machine at home? _____
8. Do you have difficulty or pain with opening your mouth widely or tilting your head back to look above you? _____
9. Asthma, wheezing: Last Attack: _____, Medications taken for Asthma treatment _____
10. Do you drink alcohol? _____ Type and amount/day _____
11. Do you use any recreational drugs (marijuana, cocaine, heroin, etc.)? _____
12. Have you ever taken Redux or Phen-Phen or any other diet pills? _____ Type and when? _____
13. Have you visited the Emergency Room within last year? _____Reason for Visit? _____
14. Recent weight loss? _____ Amount of weight lost? _____ Recent diet? _____Type? _____
15. Have you been exposed to an infectious disease in the last two weeks? _____
16. Have you ever had a blood transfusion? _____ If so, when? _____
17. Do you have a bleeding disorder, sickle cell disease, clotting abnormalities, phlebitis, including easy bruising or excessive vaginal bleeding? _____
18. Are your immunizations current? _____ Have you ever had Hepatitis immunizations? _____
19. **For Females:** Are you pregnant: Yes ☐ No ☐ Date of your last menstrual period _____

PATIENT SIGNATURE: _____

Date: _____ **Time:** _____

MEDICALTEAM

ANESTHESIA_____ Date/Time: _____

ANESTHESIA CLASS_____

NURSE _____ Date/Time: _____

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