# PREOPERATIVE QUESTIONNAIRE

Patient Label

**PATIENT NAME:** _____ AGE: _____

**DATE OF BIRTH:** _____ SEX: M F HT: _____ WT: _____

**FAMILY DOCTOR:** _____ **DATE LAST SEEN:** _____

**CITY:** _____ **PHONE:** ( ) _____

**Do you have any allergies to <u>medication?</u>** ☐ Yes ☐ No **If yes please list the allergies and reactions you have below:**

Check if an allergy or reaction to: ☐ Latex ☐ Contrast dye ☐ Adhesive tape ☐ Iodine ☐ Dairy ☐ Other _____

A. To your knowledge, do you now have or have you ever had any of the following:

| **Respiratory Problems (breathing problems)** | **Yes** | **No** |
|---|---|---|
| Recent cold, Bronchitis or Pneumonia | | |
| Asbestosis | | |
| History of Asthma or Wheezing | | |
| Sleep Apnea/Excessive Snoring | | |
| Use CPAP | | |
| Shortness of Breath with Exertion or at Rest | | |
| Emphysema / COPD | | |
| Chronic Bronchitis | | |
| Chronic cough or Lung Problems | | |
| Tuberculosis/year: _____ | | |
| **Hematologic Problems (Bleeding Problems)** | **Yes** | **No** |
| History of Anemia (low blood count) | | |
| Sickle-Cell Anemia ☐ Trait ☐ | | |
| History of Bleeding or Bruising | | |
| Blood Transfusion Year _____ | | |
| Phlebitis ☐ Blood clots ☐ | | |
| VonWillebrand disease | | |
| **Psychological Problems (Mental Health Problems)** | | |
| Anxiety ☐ Depression ☐ | | |
| Panic Disorders | | |
| Anorexia ☐ Bulimia ☐ | | |
| Post Traumatic Stress | | |
| Alzheimer's ☐ Dementia ☐ Memory Loss ☐ | | |
| Schizophrenia | | |
| Bipolar | | |
| **Musculoskeletal** | **Yes** | **No** |
| Chronic Neck ☐ Back ☐ | | |
| TMJ | | |
| Scoliosis | | |
| Arthritis CIA ☐ RA ☐ Gout ☐ | | |
| Osteoporosis ☐ Osteopenia ☐ | | |
| **Ears/Eyes** | **Yes** | **No** |
| Hearing Impaired | | |
| Deaf ☐ | | |
| Use of Hearing Aids ☐ | | |
| Glaucoma ☐ Macular Degen ☐ | | |
| Blindness ☐ | | |
| Visual Impairment ☐ | | |
| Contacts Lenses ☐ Glasses ☐ | | |

| **Cardiovascular Problems (heart or circulatory problems)** | **Yes** | **No** |
|---|---|---|
| Irregular Heart Beat | | |
| Mitral Valve Prolapse | | |
| Heart Murmur | | |
| Rheumatic Fever | | |
| High blood Pressure | | |
| Fast Heartbeat/Palpitations | | |
| Heart Attack Year_____ | | |
| High Cholesterol | | |
| Heart Failure | | |
| Chest Discomfort or Tightness | | |
| Problems with Arteries in neck | | |
| Problems with Poor circulation to legs & feet | | |
| **Gastrointestinal Problems (Digestive Problems)** | **Yes** | **No** |
| Liver Disease/Jaundice/Hepatitis | | |
| Chronic Heartburn | | |
| GI Bleed/Ulcer | | |
| Hiatal Hernia | | |
| Reflux | | |
| Crohns | | |
| Diverticulitis | | |
| IBS ☐ Ulcerative Colitis ☐ | | |
| Gastroparesis | | |
| Pancreatitis | | |
| Trouble Swallowing | | |
| **Dental** | **Yes** | **No** |
| **Caps** ☐ Implants ☐ **Crowns** ☐ | | |
| Dentures ☐ Full ☐ Partial ☐ | | |
| Veneers ☐ Bondings ☐ | | |
| Braces ☐ Retainers ☐ | | |
| Loose Where_____ | | |
| Chipped Where _____ | | |
| **Skin** | **Yes** | **No** |
| Rashes ☐ Rosaceas ☐ | | |
| Open Wounds Where_____ | | |
| Eczema ☐ Psoriasis ☐ | | |
| MRSA | | |
| Shingles | | |

| **Neurologic Problems** | | |
|---|---|---|
| Tremors ☐ Parkinson's ☐ | | |
| Stroke ☐ TIA (Mini-Stroke) ☐ Year_____ | | |
| Multiple Sclerosis ☐ Polio ☐ | | |
| Weakness or Paralysis | | |
| Head Injury Year_____ | | |
| Neuropathy | | |
| Epilepsy/Seizures Last_____ | | |
| Migraines | | |
| Vertigo ☐ Meniere's ☐ | | |
| Restless Leg Syndrome | | |
| **Endocrine Problems** | | |
| Thyroid Disorder Hyper ☐ Hypo ☐ | | |
| Parathyroid Disorder | | |
| Diabetes | | |
| Adrenal Disorder ☐ Pituitary ☐ | | |
| **Urology Problems** | | |
| Kidney Stones | | |
| Enlarged Prostate | | |
| Dialysis Peritoneal ☐ Hemo ☐ | | |
| Stress Incontinence | | |
| Urinary Tract Infections | | |
| Interstitial Cystitis | | |
| Frequency | | |
| **Developmental Problems** | | |
| Mental Retardation | | |
| Learning Disabilities | | |
| Autism | | |
| **ADHD** | | |
| **Other Problems** | **Yes** | |
| Cancer Where_____ | | |
| HIV AIDs ☐ | | |
| **B. Have you ever had any of the following:** | | |
| Card Cath | | |
| Number of Stents_____ | | |
| Pacemaker ☐ AICD ☐ | | |

St. Mary Medical Center

Patient Label

**C. Women Only:**

| | Uncertain | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|
| Are you pregnant? | | | | Are you breastfeeding? | | | |
| Recently Pregnant? | | | | Number of pregnancies _____ | | | |
| Date of last menstrual period _____ | | | | Number of live births_____ | | | |
| Menopausal ☐ Yes ☐ No How Long _____ | | | | Number of spontaneous or other abortions_____ | | | |

**Please list all previous surgeries or procedures Requiring Anesthesia. Attach additional page if necessary.**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you had any problems with anesthesia? ☐ Yes ☐ No

If yes, explain: _____

Have any of your blood relatives (Parents, Grandparents, Siblings) had problems with anesthesia? ☐ Yes ☐ No

If yes, explain: _____

**Please complete the following questions:**

Language Used: English **Other** _____

Do you have religious or moral objections to medically necessary blood transfusions? ☐ Yes ☐ No

If yes, describe: _____

Do you have any other special concerns? _____

Who will be driving you home after surgery? _____

Should we be aware of any cultural or religious beliefs that may affect your health care? ☐ Yes ☐ No

Explain: _____

_____

How can we meet your spiritual needs while you are with us for your surgery/procedure:

_____

_____

_____

_____

_____

# PREOPERATIVE QUESTIONNAIRE

Patient Label

## ADVANCED HEALTH CARE DIRECTIVE

Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No

Are you an organ donor? ☐ Yes ☐ No

Do you have a medical power of attorney? ☐ Yes ☐ No

If yes, who/relationship _____

_____

## PAIN SCREENING

1. Do you have a chronic problem with pain? ☐ Yes ☐ No
   If yes, where is your pain located? _____
2. Rate the severity of your pain: _____
   (O= no pain, 10= severe pain)

## NUTRITIONAL SCREENING

In one week how much meat do you eat? _____

Are you on any special diet? ☐ Yes ☐ No Renal ☐ Diabetic ☐ Cardiac ☐

Have you had an unintentional weight loss of more than 10 pounds over the past 3 months? ☐ Yes ☐ No

Are you a Vegetarian? ☐ Yes ☐ No

## SUBSTANCE SCREENING

Do you smoke? ☐ Yes ☐ No

Did you ever smoke? ☐ Yes ☐ No

- Cigarettes ☐ Yes ☐ No
- Chew tobacco ☐ Yes ☐ No
- Pipe ☐ Yes ☐ No
- Cigars ☐ Yes ☐ No
- Marijuana ☐ Yes ☐ No

If yes how much per day _____

Total number of years smoked _____

When did you quit smoking? _____

Do you drink alcohol ☐ Yes ☐ No

If yes how much (quantify) _____

Recovering alcoholic ☐ Yes ☐ No

If yes how long _____

Do you use Recreational drugs or IV drugs? ☐ Yes ☐ No

If yes please explain _____

_____

Do you drink coffee/tea caffeinated beverages? ☐ Yes ☐ No

If yes, how much (quantity) _____

**Please include insulin, oxygen, inhalers and any over-the-counter medications including aspirin, vitamins, herbs, minerals, and supplements.**

| Medication | Dose | Freq | Route | Purpose | Special Instructions | BR | Lunch | Dinner | Bed |
|---|---|---|---|---|---|---|---|---|---|
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**Patient Signature** _____ **Date:** _____

**Updated** _____ **Date:** _____