THE QUEEN'S MEDICAL CENTER

Anesthesia Preoperative Evaluation Center (APEC) Questionnaire

Phone: (808) 691-4874 • Fax: (808) 691-7828

Surgery Date: _____

Please ***ANSWER all questions*** as accurately as possible. This information will be entered into your permanent ***MEDICAL RECORD.***

Name: _____ DOB: _____ Current Height _____ Current Weight _____

Primary Care Physician: _____ Last visit _____

Cardiologist: _____ Last visit _____

Endocrinologist: _____ Last visit _____

Pulmonologist: _____ Last visit _____

Other Doctors: _____ Last visit _____

Date of last Blood/Lab Test (m/y) _____ Ordering doctor or location _____

Date of last EKG (m/y) _____ Ordering doctor or location _____

Date of last Chest X-Ray (m/y) _____ Ordering doctor or location _____

Date of last Stress Test/Echo (m/y) _____ Ordering doctor or location _____

Please list any **ALLERGIES** and any reactions: _____

☐ Medication(s) _____

☐ Food/Environmental _____ ☐ Latex/Rubber _____

Are you taking any **Prescription or Over-the-Counter MEDICATION**? Please include inhalers, injections, eye drops, vitamins, and herbal supplements. Please write the name of your medication, dose and frequency. (Example: Digoxin, 0.25mg, once a day).

Medication & Strength	Dose	Frequency	Medication & Strength	Dose	Frequency

Please indicate whether you have or ever had any of these **MEDICAL PROBLEMS** (check or circle all that apply).

NEUROLOGICAL/PSYCHIATRIC

- ☐ Seizures/epilepsy/convulsion
- ☐ History of stroke or mini stroke
- ☐ Brain aneurysm
- ☐ Dizziness/fainting spells/blackouts
- ☐ Psychological problems/depression/anxiety

RESPIRATORY

- ☐ Sleep apnea (CPAP or oxygen machine)
  - ☐ Snore loudly
  - ☐ Stopped breathing while asleep
  - ☐ Often feel tired during the day
- ☐ Asthma or emphysema/COPD
- ☐ Wheezing/shortness of breath/difficulty breathing
- ☐ History of tuberculosis/exposure/positive skin test (PPD)

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ History of heart attack (MI)
- ☐ Congestive heart failure/swelling of feet/ankles
- ☐ Heart murmur/heart valve disease/mitral valve prolapse
- ☐ Chest pain or angina
- ☐ Irregular heartbeat/palpitations
- ☐ Heart Pacemaker/defibrillator
- ☐ Manufacturer: _____
- ☐ Coronary angioplasty/stent
- ☐ High cholesterol

ENDOCRINE

- ☐ Diabetes (Insulin dependent/non-insulin dependent)
- ☐ Thyroid disease (low/high thyroid level)
- ☐ Other endocrine disease

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HEMATOLOGICAL

☐ Abnormal bleeding problems ☐ Anemia ☐ Blood clots

HEPATIC/GASTROINTESTINAL

☐ Liver disease/hepatitis/jaundice (yellowing of skin/eyes)
☐ Heartburn/acid reflux (GERD)/hiatal hernia
☐ History of stomach ulcers

RENAL/GYNECOLOGICAL/UROLOGY

☐ Kidney disease
☐ Do you receive dialysis? If yes, what days and where?

_____

☐ Bladder disease
☐ Enlarged prostate or frequent urination
☐ Date of last menstrual cycle: _____

OTHER

☐ History of cancer/chemo/radiation therapy
☐ Gout ☐ Lupus ☐ MRSA/VRE

MUSCULOSKELETAL

☐ Arthritis/Rheumatoid arthritis ☐ Chronic neck/back pain

Do you have an **ADVANCE DIRECTIVE/POWER OF ATTORNEY?**
☐ Yes ☐ No

Do you have any limitations to your physical activity?
☐ Yes ☐ No

Please circle any assistive device(s) that you currently use:
☐ None ☐ cane ☐ walker ☐ crutches ☐ wheelchair

Do you exercise or perform any physical activity (i.e., golfing, walking, yard work)? Please list the activities you are able to do.
☐ Yes /how much? _____ ☐ No

Have you had unplanned weight loss of 15 lbs or more within the past 3 months?
☐ Yes /how much? _____ ☐ No

☐ Yes ☐ No Have you **ever** smoked or used tobacco?
If yes, what type? _____ Packs per day? _____ Number of years used? _____
Years quit, if applicable: _____

☐ Yes ☐ No Do you drink alcohol? If yes, what type and how much/how often? _____

☐ Yes ☐ No Do you use or have a history of using illegal/street drugs?
If yes, what type and how much/how often? _____ Last used? _____

☐ Yes ☐ No Have you had any **SURGERY/PROCEDURE** in which anesthesia was used?
List type and date of surgery/procedure(s): _____
_____

☐ Yes ☐ No Have you or a family member had any problems with anesthesia (i.e., high fever, nausea, vomiting, difficulty breathing, or difficulty waking up from anesthesia)? If yes, list all problems:
_____

☐ Yes ☐ No Have you ever been told you had an airway problem during anesthesia?

☐ Yes ☐ No Do you have problems with your neck or opening your mouth wide?

☐ Yes ☐ No Were you told to stop taking any current blood thinning medication (i.e., Aspirin, Plavix, Coumadin)?
Date of last dose taken: _____

☐ Yes ☐ No Are you having any pain? If yes, where / for how long? _____
Rate pain level on a scale from 0 (lowest) to 10 (highest): _____

☐ Yes ☐ No Are you taking any steroid medication (example: Prednisone) for more than 6 months?

☐ Yes ☐ No Would you accept a blood transfusion if medically necessary? If no, state reason: _____

☐ Yes ☐ No Have you ever had a blood transfusion? If yes, when? _____

☐ Yes ☐ No Have you had a cold, cough, flu, fever, or sore throat or any of these symptoms in the past 2 weeks?
If yes, please list symptoms: _____

☐ Yes ☐ No Do you currently have any infections? If yes, indicate location: _____

☐ Yes ☐ No Do you have dental problems? If yes, what kind of dental problems do you have?
☐ Dentures / Partials: Upper/Lower ☐ Capped / Crowns / Loose / Broken / Missing teeth