THE QUEEN'S HEALTH SYSTEMS

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PRE-SURGERY CENTER PRE-OP QUESTIONNAIRE

Surgery Date: _____

When is the best time for the hospital to call you:

Monday-Friday (check one): ☐ 8 am -12 noon ☐ 12 noon - 4pm ☐ 4pm -8pm Phone #: _____

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

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

Primary Care Physician (Name): _____ Date of last visit: _____

Cardiologist (Name): _____ Date of last visit: _____

Endocrinologist/Pulmonologist/any other physicians (Name): _____

When & where did you have your last Blood/Lab Test: _____

When & where did you have your last EKG: _____

When & where did you have your last Chest X-Ray: _____

When & where did you have your last Stress Test/Echo: _____

List any **ALLERGIES** and any reactions: _____

Prescription or Over-the-Counter MEDICATIONS: Please write the names of all your medication, dose, and frequency. (Example: Digoxin, 0.25mg, once a day). Complete below or attach a list if additional space is needed.

MEDICATION & STRENGTH	DOSE	FREQUENCY	MEDICATION & STRENGTH	DOSE	FREQUENCY

Were you told to stop taking any **blood thinning medication** (i.e., Aspirin, Plavix, Coumadin)? ☐ NO ☐ YES

Date of last dose taken: _____

Are you taking any steroid medication (i.e. Prednisone) for more than 6 months? ☐ Yes ☐ No

MEDICAL PROBLEMS (Check ALL that apply):

NEUROLOGICAL/PSYCHIATRIC

- ☐ Seizures/epilepsy/convulsion
- ☐ Stroke or TIA (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
- ☐ Tuberculosis/exposure/positive skin test (PPD)
- ☐ Did you receive treatment?

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Heart attack (MI)
- ☐ Congestive heart failure/swelling of feet/ankles
- ☐ Heart murmur/heart valve disease/mitral valve prolapse
- ☐ Chest pain or angina
- ☐ Irregular heart beat/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

Continued on other side.

MEDICAL PROBLEMS (Check ALL that apply):

ENDOCRINE

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

HEMATOLOGICAL

☐ Abnormal bleeding problems ☐ Anemia ☐ Blood clots

HEPATIC/GASTROINTESTINAL

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

RENAL/GYNECOLOGICAL/UROLOGY

☐ Kidney disease
☐ Are you on 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 **ADVANCED DIRECTIVE / POWER OF ATTORNEY?**

☐ Yes Name: _____ ☐ No

Are you using any assistive device:

☐ None ☐ cane ☐ walker ☐ crutches ☐ wheelchair

Can you walk up 2 flights of stairs (14 steps up) without trouble breathing? ☐ Yes ☐ No

List any exercise/activities you are able to do? _____
_____
_____

Did you have unplanned weight loss of 15 lbs. or more in the past 3 months? ☐ Yes, how much? _____ ☐ No

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List all SURGERY/PROCEDURE(S) in which anesthesia was used _____
_____

☐ Yes ☐ No Are you being threatened, hurt, or abused by anyone? _____

☐ Yes ☐ No Do you feel safe to return home after surgery? _____

☐ Yes ☐ No Did you travel internationally in the last month? Where? _____

☐ Yes ☐ No Have you been in contact with anyone who was sick in the last month?

☐ Yes ☐ No Do you smoke or use tobacco? If yes, what type? _____ Packs per day? _____ Number of years? _____
When did you stop? _____

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

☐ Yes ☐ No Do you use illegal/street drugs? If yes, what type / how much / how often? _____ Last used? _____

☐ Yes ☐ No Did YOU or a family member have 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 been told you have an airway problem during anesthesia? _____

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

☐ Yes ☐ No Do you have any dental problems? If yes, circle below?
☐ Dentures / Partials: Upper / Lower ☐ Capped / crowns / loose / broken / missing teeth

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

☐ Yes ☐ No Have you had a cold, cough, flu, fever, sore throat or rash in the past 2 weeks?

☐ Yes ☐ No Do you have an infection or open wound? If yes, indicate location: _____