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PREOPERATIVE HEALTH QUESTIONNAIRE

Patient’s Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Today’s Blood Pressure: **\_\_\_\_ ­­­/\_\_\_\_**

Do you have Advanced Directive? □ Yes □ No

If yes, you *may* bring a copy for your surgical chart. If no, would you like Advanced Directive paperwork to fill out? □ Yes □ No

Age: **\_\_\_\_\_\_** Height: \_\_\_\_\_\_ Weight: **\_\_\_\_\_\_**

Please check Yes or No for every question.

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| **Kidney/liver/Glands** | **Yes** | **No** |
| Serious liver disease/liver failure |  |  |
| Hepatitis currently **or** in the past, if yes,  Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date / / |  |  |
| Diabetes Type \_\_\_\_\_, if yes, controlled by   insulin  pills  diet |  |  |
| Check blood sugars @home? Last reading \_\_\_\_\_\_ date: \_\_\_\_\_ |  |  |
| Kidney disease/kidney failure |  |  |
| Kidney dialysis  If yes, date of last dialysis / / |  |  |
| Thyroid disease |  |  |

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| **Brain and Nervous System** | **Yes** | **No** |
| Stroke or mini stroke (TIA) |  |  |
| Brain or nerve disorder |  |  |
| Seizure disorder or epilepsy |  |  |
| Parkinson’s Disease |  |  |
| Numbness, weakness in arms or legs |  |  |
| Alzheimer’s Disease |  |  |
| Developmentally delayed |  |  |

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| **Lungs** | **Yes** | **No** |
| Asthma, emphysema or wheezing |  |  |
| Sleep apnea |  |  |
| CPAP machine |  |  |
| Oxygen dependent, if yes, liters |  |  |
| Difficulty breathing when lying flat |  |  |

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| **Heart** | **Yes** | **No** |
| High blood pressure |  |  |
| Chest tightness or pain, angina |  |  |
| Recent fainting or blackouts |  |  |
| Heart valve disease |  |  |
| Heart valve replacement, if yes, Date \_\_\_\_/\_\_\_\_ |  |  |
| Heart murmur |  |  |
| Are you able to walk up a flight of stairs without shortness of breath? Reason |  |  |
| Congestive heart failure |  |  |
| Irregular heartbeat |  |  |
| Pacemaker |  |  |
| Automatic implanted defibrillator |  |  |
| **Heart attack, if yes,**  **Date / / \_ How many?** |  |  |
| Open heart surgery, (CABG) if yes, Date / /­­­­­\_\_\_\_\_  How many vessels were repaired? |  |  |
| Angioplasty |  |  |
| Low blood pressure |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

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| **Lungs cont.** | **Yes** | **No** |
| COPD |  |  |
| TB or positive TB test |  |  |
| Frequent cough |  |  |
| Currently smoke/vape, how much? packs per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Former smoker, when did you quit?  \_\_\_\_\_ years ago |  |  |

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| **Allergies**  **No known allergies** |   **Yes** | **No** |
| Penicillin |  |  |
| Sulfa |  |  |
| Latex |  |  |
| Betadine/ Iodine soap |  |  |
| Adhesive Tape |  |  |
| **Please list all allergies to medications** | |  |
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| **General** | **Yes** | **No** |
| Clotting or bleeding disorder |  |  |
| HIV positive or AIDS |  |  |
| MRSA positive |  |  |
| Prednisone/steroid use past 6 months |  |  |
| Chemotherapy? if yes, Date / / \_ |  |  |

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| **Muscular/Skeletal System** | **Yes** | **No** |
| Arthritis:  general  rheumatoid |  |  |
| Chronic back pain |  |  |
| Wheelchair dependent |  |  |
| Use a  walker or  cane |  |  |
| Frequent falls |  |  |

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| **Eyes, Ears, Nose & Throat** | **Yes** | **No** |
| Hard of hearing |  |  |
| Wear a hearing aid:  Right or  Left |  |  |
| Difficulty swallowing |  |  |
| Dizzy spells or vertigo |  |  |

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| **Medications**  **No medications**  Please list all medications, over-the-counter medications, vitamins, minerals, and herbal supplements (list name and dose) |
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| **Urinary** | **Yes** | **No** |
| **Females**: Pregnant? unsure N/A Menopause Hysterectomy |  |  |
| History of enlarged prostate or kidney stones, if yes, what medication? \_\_\_\_\_\_\_\_ |  |  |

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| **Stomach and Intestines** | **Yes** | **No** |
| Hiatal hernia |  |  |
| Acid reflux/heartburn |  |  |

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| **Major Surgeries or hospitalizations**  **No surgeries**  **(i.e. heart surgery, stents, MI, CABG, lung surgery; hospitalized for major infections, stroke, pneumonia, COVID or other serious surgery or hospitalization)** | |
| Surgery/hospitalization | Date |
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| **Anesthesia** | **Yes** | **No** |
| I’ve had a serious problem with an anesthetic  \_ |  |  |
| I have a relative who has had a high fever with an anesthetic (malignant hyperthermia) or other serious problem |  |  |

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| **Social History** | **Yes** | **No** |
| Consumes Alcohol: frequency \_\_\_\_\_\_\_\_\_\_ |  |  |
| Recreational Drug use: frequency \_\_\_\_\_\_\_ |  |  |
| Currently employed: occupation \_\_\_\_\_\_\_\_\_\_ |  |  |
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