Holy Family Hospital
A STEWARD FAMILY HOSPITAL
Steward

PATIENT STICKER:

DEPARTMENT OF PERIOPERATIVE SERVICES
PRE-OPERATIVE MEDICAL QUESTIONNAIRE
AND ASSESSMENT DATA FORM

General patient information: Completed by: □ Patient □ Guardian □ Admitting Nurses

Name: _____ Date of Birth: _____/_____/_____
(Last, First and Middle Initial)
Age: _____ Sex: □ M □ F Height: _____ Weight: _____ lbs
Fluent in English: □ Yes □ No Primary language Spoken: _____
Home Phone #: _____ (C): _____ (W): _____
Surgeon Name: _____ Expected Date of Surgery: _____/_____/_____
Primary Care Physician: _____ PCP Phone #: _____
Cardiologist Name: _____ Phone #: _____
Telephone to be Reached Prior to Surgery: _____
Best time to call: □ Morning □ Afternoon □ Evening May we leave a message? □ Yes □ No
Living situation: □ Alone □ With family □ Assisted living □ Nursing home

ADVANCED DIRECTIVES/HEALTH CARE PROXY

Do you have an advanced directive: □ Yes □ No
If no, would you like to receive information: □ Yes □ No

ACTIVITIES OF DAILY LIVING

Do you currently have any pain issues: □ Yes □ No
Where is the pain located: _____ Pain scale: ___/10 pain
Are you able to perform your daily activities on your own: □ Yes □ No
If no, are you currently receiving assistance: □ Yes □ No By whom: _____

ALLERGIES

Do you have any allergies: □ Yes □ No
If yes, to what: □ Food □ Drug □ Latex □ other _____
Please list any drug or food allergies that you have below along with the reaction you have had:
(An additional list may be attached to this form should you need more room)

Allergen	Reaction
1.	
2.	
3.	
4.	
5.	

SURGERIES

Please list all prior surgeries and procedures, date and complications, if any:
(An additional list may be attached to this form should you need more room)

Surgery	Date	Complications (if any)
1.		
2.		
3.		
4.		
5.		

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MEDICATIONS

Please list all your medications, supplements and herbals and include the dosage and frequency:
(An additional list may be attached to this form should you need more room)

***** PLEASE NOTE ANY ORAL STEROID USE IN THE PAST SIX MONTHS**

Medication	Dosage (mg)	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Please list family health history, specifically your parent's, brothers/sisters and your children:

_____

_____

_____

Please list any complications/problems experienced with anesthesia:

_____

_____

_____

Please answer the following "YES/NO" questions by placing an "X" under the appropriate answer and provide further information where needed.

	YES	NO
CARDIAC HISTORY:		
Do you have a history of irregular heartbeat, atrial fibrillation or palpitations?		
Do you have a history of high blood pressure?		
Have you ever had a heart attack, heart disease, chest pain or heart failure?		
Have you ever had a heart murmur, mitral valve prolapse or a heart valve problem?		
Did you ever have a blood clot in your leg? If so, did it travel to your lung:		
Have you ever had heart surgery?		
Have you ever had a catherization of your heart? Date: Where:		

PATIENT STICKER:

	YES	NO
Do you have cardiac stents? If so, what type (bare metal or drug eluding):		
Have you ever had an EKG, heart stress test, echocardiogram or other cardiac testing? Test: Date: Where: Test: Date: Where: Test: Date: Where:		
Have you ever been told to take antibiotics prior to a surgical procedure or dental work?		
Do you have a pacemaker or implantable defibrillator (AICD)? Date implanted: Where: **Please ask your cardiologist to send the most recent pacemaker interrogation to the surgeon and bring your information card with you on the day of pre-admission testing and surgery.		
RESPIRATORY HISTORY:		
Do you get shortness of breath on exertion or swollen ankles?		
Do you wake up at night short of breath?		
Have you ever had Tuberculosis (TB)?		
Do you have a history of smoking?		
Do you use a machine at home to help you breath?		
Do you have severe emphysema, asthma or bronchitis (COPD) that limits your activities?		
Do you have sleep apnea?		
Do you snore loudly or been told that you gasp, choke, snort or stop breathing during sleep?		
Do you use a BiPAP or C-PAP machine at home? If so, at what setting:		
SKIN/EYES/EARS/DENTAL:		
Have you ever been diagnosed with an infection such as MRSA, VRE or C. difficile? If so, where was the infection located: When:		
Do you have glaucoma or cataracts?		
Do you wear glasses or contacts?		
Do you have any dental implants, dentures, crowns, bonding or braces? If so, which do you have:		
Do you have hearing loss? If so, do you wear hearing aids:		
ENDOCRINE/RENAL/GASTROINTESTINAL DISORDERS:		
Do you have a history of diabetes?		
Do you have a history of adrenal or thyroid disease or tumor?		
Do you have a history of kidney disease or kidney stones?		
Do you use steroids (Prednisone)?		
Do you have a loss of appetite or unintentional weight loss in the past year?		
Are you on dialysis? If so, when where you last dialyzed:		
Do you have a history of hepatitis, cirrhosis or liver failure? If you have a history of hepatitis, which form: A, B or C		
Do you have acid reflux? If so, is it controlled with medication:		
BLOOD DISORDERS AND BLOOD TRANSFUSION HISTORY:		
Do you have a history of anemia or low blood count?		
Do you have sickle cell disease or trait?		
Do you use Warfarin (Coumadin) or Plavix as a blood thinner? If so, which do you use and for what:		
Do you bruise easily and/or have a bleeding problem?		
Have you had a blood transfusion in the past?		
Have you had a reaction or allergy to a blood transfusion?		
Did you donate blood for this surgery?		

PATIENT STICKER:

	YES	NO
MUSCULOSKELETAL/NEUROLOGICAL:		
Do you have a history of stroke or seizures?		
Do you have weakness in your arms or legs?		
Do you have a history or neck, back or head injuries?		
Do you have chronic pain or a history of gout?		
Do you have a Rheumatoid arthritis, Raynaud's disease or Lupus?		
Do you have Multiple Sclerosis?		
Do you have scoliosis?		
REPRODUCTIVE/OBSTETRICS:		
Are you or do you believe you might be pregnant? Last menstrual cycle:		
Have you been pregnant in the last 3 months?		
CANCER:		
Do you have a history of cancer? If so, what type of cancer :		
Have you received radiation therapy or chemotherapy?		
Have you had an axillary (under arm) lymph node dissection? If so, which side:		
ANESTHESIA RELATED ISSUES:		
Has anyone had problems placing a breathing tube in your windpipe (trachea) for surgery?		
Have you had surgery on your throat, vocal cords or lungs?		
Have you had an allergic or life-threatening reaction to anesthesia?		
Do you or any of your relatives have a history of Malignant Hyperthermia?		
Do you have trouble opening your mouth or bending your neck forward or backward?		
BEHAVIORAL HEALTH:		
Have you suffered from anxiety, depression or a psychiatric disorder? If so, please describe:		
Do you consume alcohol? If so, how much per week: Last use:		
Do you use recreational drugs or have a history of substance abuse? If so, what and how often: Last use:		
PEDIATRIC QUESTIONS: For patients under the age of 10		
Was your child full-term or premature? If premature, by how many weeks:		
Has your child been reaching the milestones appropriate for their age? If not, please briefly explain:		
Are your child's immunizations up to date?		
Has your child been recently exposed to any illnesses?		

Addendum: _____
_____
_____

Patient/Guardian Signature: _____ Date: ____/_____/_____

Nurse Signature: _____ Date: ___/_____/_____ Time: _____

Questionnaire verified by: □ phone □ in person

Interpreter Services: □ Yes □ No **Name**: _____

(Pilot 9/11)