PRE-OPERATIVE QUESTIONNAIRE

Patient Name _____ Phone _____

Surgeon Name _____ Phone _____

Type of Surgery _____

PLEASE BRING IN ALL MEDICATIONS IN THEIR VIALS, PROPERLY LABELED

In order to safely care for you at the time of surgery, we would like to become familiar with your medical and surgical history. Please complete both sides of this form, and bring it with you when you come to the hospital for your pre-admission testing. At that time, a nurse will discuss your history in more detail, and give you further instructions. Please call the Operating Room at (315) 824-6171 if you have any questions.

1. Age:_____ Height:_____ _____ Weight: _____

2. **Medications:** Please list all medications: Name - dose - time it is taken, how many tablets and why.

3. **Medication Allergies:** Please list them, and what your reaction is.

All Other Allergies and Reactions

4. Are you allergic to latex/rubber? _____ yes _____ no

5. **Past Surgeries:** Please list them, and when you had them.

6. **Past Anesthesia:** What types of anesthesia have you had in the past?

   General Spinal Epidural Sedation

7. **Anesthesia Reactions:** Have you or any relative had one?
   If yes, explain.

(over)

Community Memorial Hospital
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8. **Smoking:** Do you now, or have you smoked in the Past? _____ Yes _____ No
   How many packs/day? _____ how many years? _____ Quit when? _____
9. **Chewing Tobacco:** Do you use any? _____ Yes _____ No
10. **Alcohol:** Do you drink alcoholic beverages? _____ Yes _____ No
    If yes how often and how many Daily_____ / Weekly_____/ Monthly_____/ less than monthly_____
12. **Recreational Drugs:** Do you use any? _____ Yes _____ No

Please check mark those that apply to the patient, now or in the past.

Cardiovascular

_____ High blood pressure _____ Abnormal Heart beat _____ Pacemaker/defibrillator
_____ Heart Murmer / Valve Disease / Mitral Valve Prolapse
if so, do you take antibiotics when you see the dentist?
_____ Heart attack; if so, when? Chest Pressure / Pain / Angina
_____ Heart failure _____ Previous Stress Tests / Catheterization
Date: _____ Date: _____
Name of Cardiologist:_____ Name of Hospital:_____

Lungs

_____ Asthma _____ Tuberculosis _____ Lung infection _____ COPD / emphysema
_____ Recent cold or cough _____ Sinus / Allergies _____ Sleep apnea

Neurologic

_____ Black outs _____Seizures _____ Strokes / TIA _____ Numbness / tingling
_____ Difficulty hearing, seeing or glaucoma
_____ Back Problems _____ any other nerve disease

Other

_____ Anxiety / Depression
_____ Diabetes _____ Hepatitis, Jaundice, or Liver Disease
_____ Heartburn, Hiatal hernia, Stomach Ulcers, Reflux, GERD
_____ Thyroid Disease _____ Kidney Disease _____ Major injury, accident
_____ Bleeding Tendencies or easy bruising
_____ Arthritis _____ Cancer _____ Prior blood transfusion (list year)
_____ Do you have any loose teeth / caps / bridges / braces / dentures / contact lenses / hearing aids
or other medical aids (specify) _____

Ladies: Are you breastfeeding? (Yes / No)
Is there **ANY** chance that you could be pregnant? (Yes / No)

Everyone: List anything else that you think we should know

What is your family doctor's name?_____
What is your family doctor's telephone number? _____

Signature of RN reviewing form _____ Date_____ / _____ / _____