Presurgical Patient Questionnaire

Patient Name: _____ Phone number: _____ Email: _____

What is your Age? _____ Height? _____ Weight? _____ lbs. Religious Preference: _____

Home Address: _____

Primary Care Provider Name and Phone Number: _____

Pharmacy Name, Location and Phone Number: _____

Emergency Contact Name and Phone Number: _____

Please list any allergies and the types of reactions:

Allergy	Reaction	Allergy	Reaction

Please list your current medications, including herbal supplements, vitamins, and diet pills:

Medication	Dosage	How often?	Medication	Dosage	How often?

*See Last Page for Additional Medications

Please list your previous surgeries/procedures and any complications:

Approx Date	Procedure	Complications	Approx Date	Procedure	Complications

Patient Identification/Label

Presurgical Patient Questionnaire

Medical History: Have you EVER had any of the following? (Please circle YES or NO)

*Indicates need for additional information

Heart or Vascular Problems

- ☐ **Yes** ☐ **No** High blood pressure or hypertension?
- ☐ **Yes** ☐ **No** High cholesterol or hyperlipidemia?
- ☐ **Yes** ☐ **No** Do you get chest pain or shortness of breath when you climb stairs or walk up a hill?
- ☐ **Yes** ☐ **No** Coronary artery disease, angina (chest pain), heart attack, angioplasty (balloon), cardiac stent?
- ☐ **Yes** ☐ **No** *Abnormal* stress test, heart catheterization, echocardiogram (echo), or electrocardiogram (EKG)?
- ☐ **Yes** ☐ **No** Congestive heart failure (CHF/Fluid in the lungs)?
- ☐ **Yes** ☐ **No** Cardiac arrhythmia or irregular heartbeat (atrial fibrillation)?
- ☐ **Yes** ☐ **No** Pacemaker? *If Yes, please complete Pacemaker-ICK Form (page 3 of this Questionnaire).*
- ☐ **Yes** ☐ **No** ICD (implantable cardioverter defibrillator)? *If Yes, please complete Pacemaker-ICD Form.*
- ☐ **Yes** ☐ **No** Severe disease of the aortic or mitral heart valves (aortic/mitral stenosis, aortic/mitral insufficiency)?
- ☐ **Yes** ☐ **No** Peripheral vascular disease?

Respiratory or Breathing Problems

- ☐ **Yes** ☐ **No** Have you *ever* smoked? Packs per day? _____
- ☐ **Yes** ☐ **No** "Wheezing", COPD (Emphysema, chronic bronchitis) or Asthma?
- ☐ **Yes** ☐ **No** Do you use oxygen at home?
- ☐ **Yes** ☐ **No** Have you visited the emergency room for breathing problems in the past 2 years?
- ☐ **Yes** ☐ **No** Upper respiratory infection or new productive cough within the past week?
- ☐ **Yes** ☐ **No** Sleep apnea? If so, do you use CPAP to sleep? Yes____ No____

Neurologic Problems

- ☐ **Yes** ☐ **No** Stroke (CVA) or mini-stroke (TIA)? If yes, when? _____
- ☐ **Yes** ☐ **No** Seizures or epilepsy? If yes, when was your last seizure? _____
- ☐ **Yes** ☐ **No** Neck pain and/or back pain?
- ☐ **Yes** ☐ **No** Peripheral neuropathy (numbness or tingling in hands, arms, feet, or legs?

Endocrine or Metabolic Problems

- ☐ **Yes** ☐ **No** Diabetes?
- ☐ **Yes** ☐ **No** Thyroid Disease?
- ☐ **Yes** ☐ **No** Have you taken steroids *within the last year* to treat breathing problems or arthritis?

Gastrointestinal or Liver Problems

- ☐ **Yes** ☐ **No** Inflammatory bowel disease (Crohn's or Ulcerative colitis)?
- ☐ **Yes** ☐ **No** Hiatal hernia, GERD (gastroesophageal reflux disease) or peptic ulcer disease?
- ☐ **Yes** ☐ **No** Cirrhosis of the liver?
- ☐ **Yes** ☐ **No** Hepatitis B or C?

Presurgical Patient Questionnaire

Kidney Problems	
☐ Yes ☐ No	Kidney failure requiring dialysis? If yes, what days of the week do you receive dialysis? _____
Blood Problems	
☐ Yes ☐ No	Anemia (low red blood cells)?
☐ Yes ☐ No	Thrombocytopenia (low platelet count)?
☐ Yes ☐ No	Blood clotting problems or excessive bleeding (Hemophilia, von Willebrand's disease)?
☐ Yes ☐ No	Sickle cell disease or trait?
☐ Yes ☐ No	Deep venous thrombosis (DVT) or pulmonary embolism (PE)?
☐ Yes ☐ No	Do you take any blood thinners (anticoagulants)?
☐ Yes ☐ No	HIV/AIDS?
Anesthesia Problems	
☐ Yes ☐ No	Do you have a personal or family history of malignant hyperthermia or porphyria?
☐ Yes ☐ No	Told that it was difficult to place a breathing tube in your airway (intubation)?
☐ Yes ☐ No	Had severe nausea/vomiting or other severe reaction after anesthesia?
Other	
☐ Yes ☐ No	Cancer? If yes, what kind? _____(*Head/Neck)
☐ Yes ☐ No	Do you refuse to receive a blood transfusion if medically necessary?
☐ Yes ☐ No	Rheumatoid arthritis, Lupus or other autoimmune disease?
☐ Yes ☐ No	Is there a possibility you may be pregnant? Date of last menstrual period _____
☐ Yes ☐ No	Do wear Glasses, Contact lenses or Hearing aids?
☐ Yes ☐ No	Do you require the use of an assistance device, like a cane and/or walker?
☐ Yes ☐ No	Do you have any trouble sleeping? Do you take any sleep aids?
☐ Yes ☐ No	Do you drink alcoholic beverages? Average number of drinks per week _____
☐ Yes ☐ No	Have you ever, or currently use recreational drugs?
☐ Yes ☐ No	Have you recently taken Antibiotics? If yes, what reason? _____
☐ Yes ☐ No	Any adverse reactions with Antibiotics? (Nausea/Vomiting/Diarrhea)? _____
☐ Yes ☐ No	Do you have any metal in your body? If yes, where?
☐ Yes ☐ No	Have you traveled outside the United States in the last 3 months?
☐ Yes ☐ No	Do you have a history of falls? If yes, any falls in the last 3 months?
☐ Yes ☐ No	Anything else about your medical history not mentioned above? If yes, please explain: _____
☐ Yes ☐ No	Do you live alone?
☐ Yes ☐ No	Do you have a responsible adult to bring you home following your procedure? What is their name and phone number? _____
☐ Yes ☐ No	Do you have an advanced directive, medical power of attorney or living will?

Patient Identification/Label

Presurgical Patient Questionnaire

Please provide the following information if you have a pacemaker and/or ICD (defibrillator):

If your pacemaker or defibrillator has not been interrogated in the last 12 or 6 months, respectively, please contact your cardiologist.

If you are unable to complete the following please obtain the information from your cardiologist's office or device company representative (see below).

Pacemaker Brand/Model: _____

Last Interrogation (Device Evaluation within last 12 months): _____

Battery Life Greater than 3 Months: Yes ☐ No ☐

ICD (Defibrillator) Brand/Model: _____

Last Interrogation (Device Evaluation within last 6 months): Date _____

History of Events (Shocks): Never: _____ Date of Last Shock: _____

Battery Life Greater than 3 Months: Yes ☐ No ☐

_____

Signature of Patient or Guardian

Please list your current medications, including herbal supplements, vitamins, and diet pills:

Medication	Dosage	How often?	Medication	Dosage	How often?

Patient Identification/Label