

PREANESTHETIC PATIENT PREPARATION

Appropriate preoperative testing, medical and/or specialty clearance, and completion of the Preoperative and Pre-Anesthetic Patient Questionnaire are required for your patient to be cleared for surgery. Based on the questionnaire results, some patients *may* require further evaluation or consultation. Please follow the instructions below for your patients scheduled for surgery.

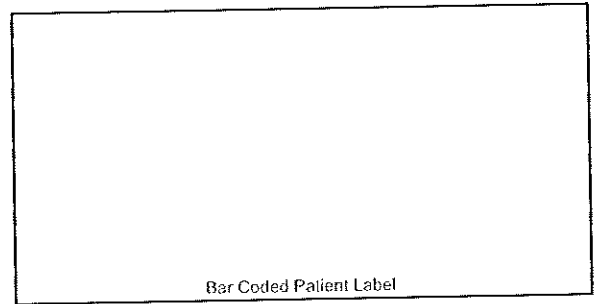
Process for completing the Questionnaire:

1. Have the patient complete the questionnaire during the office visit.
2. Once the questionnaire is completed, fax the completed questionnaire to 410-922-6031. Retain a copy for your records and have the patient bring a copy with him /her the day of surgery.
3. When the questionnaire has been received, clinical staff will review the information and notify you if further preoperative evaluation is needed.

We appreciate your support and assistance in preventing case cancellations and/or delays by ensuring patients are cleared and ready for surgery.



**PREOPERATIVE AND
PREANESTHETIC
PATIENT QUESTIONNAIRE**



Bar Coded Patient Label

Date Completed: _____

Dear Patient,

This questionnaire will help your anesthesia team determine what if any preoperative work up you will need prior to your surgery. It will also help them gather all available medical information about you. Please answer the questions as best you can. This information will help to lessen any delay in your surgery.

Thank You!

Name: _____

Age: _____ Height: _____ Weight: _____ Date of Birth: _____

Surgeon: _____ Proposed Surgery: _____

Proposed date of surgery: _____

Your contact information:

Home phone: _____ Work phone: _____

Cell phone or pager : _____ E-mail address: _____

Best time to reach you: AM PM

Best way to reach you: home work cell/pager email

Do you have a primary care doctor? Yes No

Name: _____

Address and phone number: _____

Do/Did you ever smoke? Yes No

How many packs per day? _____

How many years? _____

If applicable, when did you quit? _____

Do/Did you ever drink alcohol? Yes No

How often? _____

How much? _____

If applicable, when did you quit? _____

Do/Did you ever use "street" drugs? Yes No

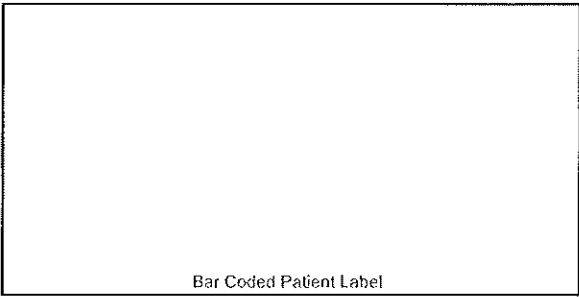
What drug? Cocaine Heroin Marijuana Other: _____

Did you ever use IV drugs? Yes No

If applicable, when did you quit? _____

Please use the last page of this questionnaire to list all you medications, including over the counter, herbals and vitamins, as well as "as needed" medications.

**PREOPERATIVE AND PREANESTHETIC
PATIENT QUESTIONNAIRE**



Bar Coded Patient Label

Do you have any allergies to medications? Yes No

Drug: _____ What happens? _____
Drug: _____ What happens? _____
Drug: _____ What happens? _____
Drug: _____ What happens? _____

Do you have any allergies to substances other than medications? Yes No

(Check all that apply)

Betadine/Iodine Latex Eggs Other: _____
 Gadolinium IV contrast Tape

List all the surgeries you have had in the past (most recent first)

(Use back of page for additional information)

Year: _____ Surgery: _____ Hospital: _____
Year: _____ Surgery: _____ Hospital: _____
Year: _____ Surgery: _____ Hospital: _____
Year: _____ Surgery: _____ Hospital: _____

Have you or anyone related to you ever had a major complication that was related to receiving anesthesia? Yes No

Have you had blood drawn for testing in the past three months? Yes No

Date: _____ Place : _____

Have you had a chest x-ray in the past year? Yes No

Date: _____ Place : _____

Have you ever had an EKG done? Yes No

Date: _____ Place : _____

Date: _____ Place : _____

Have you ever had any heart problems (for example, congestive heart failure, angina (chest pain), heart attack, arrhythmia)? Yes No

Date: _____ Problem : _____ Hospital : _____

Date: _____ Problem : _____ Hospital : _____

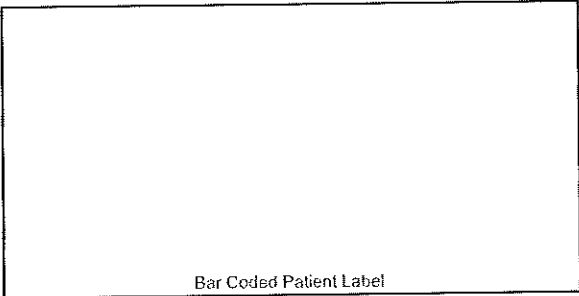
Date: _____ Problem : _____ Hospital : _____

Do you have an Automatic Internal Cardiac Defibrillator (AICD) or pacemaker? Yes No
If "Yes", do you know the model and the name of the maker?

Please bring your device pocket card with you to the hospital.

Model _____ Company _____

**PREOPERATIVE AND PREANESTHETIC
PATIENT QUESTIONNAIRE**



Have you ever had any special heart tests? (for example, stress tests, echocardiograms, cardiac catheterization) Yes No

Date: _____ Test : _____ Place : _____
Date: _____ Test : _____ Place : _____
Date: _____ Test : _____ Place : _____

Can you climb one flight of stairs without stopping? Yes No

Please describe your physical activities. (i. e. exercise often, run regularly, play tennis, able to mow lawn, poor exercise tolerance, get short of breath frequently, mostly sitting down throughout the day) _____

Have you ever had a lung function test (spirometry)? Yes No

Date: _____ Place : _____

Have you ever been diagnosed with any of the following (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Bleeding or clotting problems | <input type="checkbox"/> Stroke or mini stroke |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> GERD/Reflux/Heartburn | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> High Blood Pressure | |

**Specialists you are currently seeing or have seen in the past five years:
(You do not need to list your surgeon for the proposed procedure here).**

Cardiologist Name: _____	Phone: _____
Pulmonologist Name: _____	Phone: _____
Nephrologist Name: _____	Phone: _____
Hematologist Name: _____	Phone: _____
Oncologist Name: _____	Phone: _____
Gastroenterologist Name: _____	Phone: _____
Other Name: _____ Specialty: _____	Phone: _____
Other Name: _____ Specialty: _____	Phone: _____

Have you been diagnosed with obstructive sleep apnea? Yes No

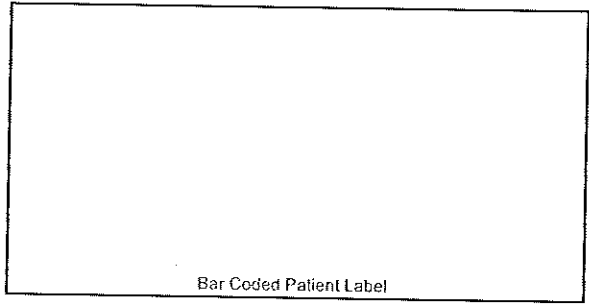
Do you use CPAP/BiPAP? Yes No

Have you had a sleep study? Yes No

Date: _____ Place: _____

Are there any specific things you would like your anesthesiologist to know?

**PREOPERATIVE AND PREANESTHETIC
PATIENT QUESTIONNAIRE**



Name _____

Date _____

MEDICATION LIST

Please use this sheet to list out your medications. Please include vitamins, minerals, herbal supplements and other over the counter (OTC) medicines that you take even if they were not prescribed by your doctor. It is important to list everything you take even if you only take them once in a while or if only as needed. We need to know because it may affect you during and after surgery and some medicines (even herbal supplements) can interact with other medications you receive during your hospital stay. If you are not sure about your medication or pills, bring everything with you when you come in, so that the nurse or doctors can review them with you.

Name of medicine, vitamin or supplement	How much do you take? (Tablets and milligrams if you know)	How often do you take this medicine? (once a day, or more or less often)	What is the reason you are you taking this medicine?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			