

PRE-OPERATIVE ASSESSMENT QUESTIONAIRE

**Patient Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Age**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sex**: M / F **Height**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **BMI**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PCP Name/#**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Procedure:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any Drug/Food Allergies**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Latex Allergy:**  Y / N

**Please list your current medications** (Including prescription, OTC, vitamins, natural, dietary or herbs)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication** | **Dose/Frequency** | **Reason** |  | **Medication** | **Dose/Frequency** | **Reason** |
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**Do you/your family have a history of Anesthesia Complications?** (MH, N/V, Pseudocholinesterase Deficiency…) Y / N

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark below if you have or have had any of the following concerns, if not applicable please leave box blank.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Cardiac/Vascular** | | **Nerve Disease** | | **Bleeding Problems** | | **Dental/Vision/Hearing** | |
|  | Heart Attack |  | Stroke |  | Bruise Easily |  | Dentures/Partials |
|  | Heart Failure |  | TIA |  | Nose Bleeds |  | Crowns |
|  | Heart Murmurs |  | Numbness/weakness |  | Blood Transfusions |  | Chipped/Cracked Teeth |
|  | Chest Pain |  | Seizures |  | Anemia |  | Loose Teeth |
|  | Abnormal EKG |  | Psychiatric Illness | **Thyroid/Liver/Kidney/GI** | |  | Gum Disease |
|  | Irregular HR:………………… |  | Fibromyalgia |  | Hypo/Hyper |  | Contact Lenses |
|  | Pacemaker | **Respiratory/Lungs** | |  | Hepatitis |  | Glasses |
|  | Cardiac Defibrillator |  | Asthma |  | Diabetes |  | Glaucoma |
|  | Peripheral Vascular Dis. |  | Bronchitis |  | Baseline |  | Hearing Aid |
|  | Blood Clots |  | COPD |  | Kidney Disease | **Other** | |
|  | High Blood Pressure |  | Pneumonia |  | Dialysis |  | Motion Sickness |
|  | High Cholesterol |  | Tuberculosis |  | Hiatal Hernia |  | Fainting |
| **Bone/Joint Problems** | |  | Abnormal Chest X-ray |  | Acid Reflux |  | Drug/Substance Abuse |
|  | Arthritis |  | Heavy Snoring | **Shortness of Breath?** | |  | Infections(MRSA, C. Diff) |
|  | Back Problems |  | Sleep Apnea (C-PAP) |  | When Laying Flat |  | AIDS/HIV |
|  | Steroid/Cortisone Use |  | Recent Cold/Flu |  | Walk w/out SOB:………ft |  | Cancer |

**Do you have any other medical problems not listed above?** Y / N If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you drink alcohol?** No / Yes If yes, how often and amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke?** Y / N If you have quit, when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you pregnant?** Y / N Date of last menstrual cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were you asked to, or have you had lab work performed prior to procedure?** Y / N

If yes, where did you have the lab work drawn?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you scheduled for a pre-op EKG or have you had one within the past year?**  Y / N

If so, where was the EKG done?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a ride home?** Y / N Please note all patients MUST have a ride to **and** from their procedure. We do not accept Uber or Lyft to be a proper ride home. If you need resources for a proper ride as you do not have a friend or family member to fulfill this role, please contact our office.

**Do you have a responsible person to stay with you for 24 hours following surgery?** Y / N

Please list below any surgeries you have had in the past:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Previous Procedure** | **When?**  **Month & Year** | **General**  **Anesthesia?** | **Nerve Block?** | **Spinal/ Epidural?** | **Local w/ sedation?** | **Complications?** |
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**PRE-VISIT INSTRUCTIONS**

Ride Home: For your safety and protection you must have transportation home from a responsible person and someone to stay with you for the first 24 hours after surgery.

**Local anesthesia**: Able to eat and drink

**GI Cases:** EGD you may have clear liquids (yellow or green ONLY)

up to 2 hours before your arrival time. Colonoscopy only water

up to 2 hours prior to the procedure.

**All others**: DO NOT eat or drink anything after midnight.

Leave all jewelry and valuables at home.

Bring photo ID, insurance cards, and form of payment with you on surgery day.

Wear loose comfortable clothes and comfortable shoes. If you are having shoulder surgery, please wear a button-up shirt or zip up sweatshirt.

Bring emergency medications with you to Tracy Surgery Center.

If you have any change in your medical condition to include any of the following symptoms or if you have been exposed to someone with COVID, please notify us as soon as possible.