Name:
DOB:
MRN
Gender:
Email address:
Home:
Cell:

Pre-Op Health History Patient Questionnaire
Department of Anesthesiology

Please complete this health history questionnaire to the best of your ability and give it to your surgeon's office team. If you are not sure of any answer, check "Not Sure". You can add details in the "Please explain/specify" section. Failure to fill out this form completely may delay your surgery.

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HEART					
Do you have:	**Yes**	**No**	**Not Sure**	**Please explain:**	
1. Any heart problem? (e.g. heart attack, murmur, angina, blockages, angioplasty, stent, valve problems, irregular heartbeat, heart surgery, heart failure).					*
2. High Blood Pressure or take medication for high blood pressure?					
3. Chest pain or breathlessness after climbing one flight of stairs?					*
4. A pacemaker or an implantable defibrillator?					*
5. Do you take Aspirin (ASA) regularly?					
6. A prescription for blood thinners? (e.g. warfarin, coumadin, plavix, dabigatran, rivaroxaban)					*
7. An artificial heart valve?					*
8. Any other heart issues?					*
BREATHING					
Do you have:	**Yes**	**No**	**Not Sure**	**Please explain:**	
9. Have you smoked tobacco of any kind in the past? Please indicate which (e.g. cigarettes, cigars, pipes, marijuana, vapes) and for how long?					
10. Emphysema, chronic obstructive pulmonary disease (COPD) or Asthma?					
11. Asthma needing your relief medication more than twice per week or oral steroids in the last 2 months?					*
12. Do you use oxygen at home to help you breathe?					*
13. A problem lying flat for at least 30 minutes because of difficulty breathing?					*
14. Have you had any chest infection for which you have been admitted to the hospital for the last 2 months?					*
15.Have you been diagnosed with COVID-19 in the last 2 months?					
16. Do you have sleep apnea?					

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17. Have you been told to use a machine to help you breathe at night but choose not to use it?					
18. Do you have any other breathing issues?					
BLOOD PROBLEMS					
Do you have:	**Yes**	**No**	**Not Sure**	**Please explain:**	
19. Sickle Cell Anemia?					*
20. Anemia (low blood count)?					
21. A bleeding disease or a clotting problem?					*
22. Do you have any personal or religious reasons for refusing to have any blood products given to you?					*
NEUROLOGICAL					
Do you have:	**Yes**	**No**	**Not Sure**	**Please explain:**	
23. Significant memory loss or dementia?					
24. A disease that affects your muscles and nerves?					*
25. A stroke or mini-stroke/TIA?					*
26. An aneurysm?					*
27. Epilepsy or convulsions?					*
OTHER IMPORTANT MEDICAL CONDITIONS					
Do you have:	**Yes**	**No**	**Not Sure**	**Please explain:**	
28. Fainting spells in the last year?					*
29. Have you or your family (blood relatives) had serious problems following an anesthetic other than nausea or vomiting (e.g. malignant hyperthermia)?					*
30. Trouble opening your mouth, jaw or moving your neck up and down?					*
31. Do you take narcotics (like codeine, morphine, hydromorphone, Percocet, methadone or suboxone) for chronic pain?					*
32. Are you pregnant/a possibility of being pregnant?					
33. Are you diabetic?				□ On Insulin* □ On Diabetic pills □ Diet Controlled	*
34. Are you on dialysis?					*
35. Do you have any kidney disease aside from kidney stones?					*

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36. Do you have thyroid disease?					
37. Are you HIV positive?					*
38. Do you have liver disease?					*
39. Have you had an organ transplant (other than cornea)?					*
40. Do you have stomach ulcers, heartburn, or a hiatus hernia?					
41. Do you have an autoimmune disease? (e.g. lupus)?					*
42. Do you have arthritis?				□ Rheumatoid Arthritis*	*
				□ Osteoarthritis	
43. Do you have any mental health concerns? (e.g. anxiety, panic attacks, claustrophobia, needle phobia etc.)					
44. Do you have/have you had cancer?					*
45. Have you had Chemotherapy/Radiation treatment?				□ To the head or neck *	*
				□ Other:	
46. Do you use any street drugs other than marijuana?					
Please indicate your average alcohol consumption per week					
List any food / drug / latex allergy					

Most Recent Height:	**Most Recent Weight:**
INDICATE PHARMACY NAME AND TELEPHONE NUMBER	
Your pharmacy name:	Phone number (or location of pharmacy):

LIST ALL OF THE MEDICATION THAT YOU TAKE (HERBAL MEDICATION, VITAMINS, AND NON PERSCRIPTION DRUGS.) ATTACH LIST IF NECESSARY.	
1.	9.
2.	10.
3	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

LIST ALL PREVIOUS AND UPCOMING SURGERIES:	
1.	4.
2.	5.
3.	6.

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Do you have any other illnesses, limitations or any other concerns we should know about?

Patient Health History Questionnaire completed by:

□ Patient □ Family □ Healthcare Provider

□ Other (specify):

IMPORTANT: Please remember to let your surgeon know if you think you are getting a cold or flu or illness before you start taking any new medication.

Declaration:
I hereby declare that the information provided above is true and correct to the best of my knowledge. I also understand that any false statements or deliberate omissions on this form may result in receiving inadequate medical care.

Print name: **Signature:** **Date (yyyy/mm/dd):**

Time:

FOR PRE-ADMISSION USE ONLY

Pre-Admission Unit Appointment Type:
□ RN Assessment (Clinic Visit)
□ RN Telephone
□ Anesthesia/RN Assessment (Clinic Visit)
□ Other (specify):
□ Chart Review

Patient Questionnaire Reviewed by:
□ Pre-Admission Unit RN
□ Other

Notes:

Print name: **Signature:** **Date (yyyy/mm/dd):**

Time: