

MARYSVILLE SURGICAL CENTER
PATIENT PREOPERATIVE QUESTIONNAIRE

PATIENT LABEL

PLEASE ADDRESS ALL QUESTIONS: (place checkmark before items).

HEART: <input type="checkbox"/> No Problems <input type="checkbox"/> High Blood Pressure	AGE	HEIGHT	WEIGHT	(BMI)
<input type="checkbox"/> Chest pain <input type="checkbox"/> Heart Attack <input type="checkbox"/> Murmur <input type="checkbox"/> Irregular Heart Beat				
<input type="checkbox"/> Heart Failure <input type="checkbox"/> Pacemaker/Implanted Defibrillator	LIST MEDICATIONS/ HERBALS/ VITAMINS that you are presently taking. (Include name of drug, dose and how often it is taken.) <input type="checkbox"/> None			
<input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Other:	1.		6.	
EKG within the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	2.		7.	
LUNGS: <input type="checkbox"/> No problems <input type="checkbox"/> Recent Cold <input type="checkbox"/> Asthma	3.		8.	
<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> COPD	4.		9.	
<input type="checkbox"/> Sleep Apnea: If yes: <input type="checkbox"/> CPAP <input type="checkbox"/> BIPAP	5.		10.	
Machine Pressure Settings:				
<input type="checkbox"/> Home Oxygen _____ Liters				
<input type="checkbox"/> Other:				
	ASPIRIN? <input type="checkbox"/> No <input type="checkbox"/> Yes: How many/day?			
STOMACH: <input type="checkbox"/> No Problems <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Ulcer	ALLERGIES TO MEDICATIONS? <input type="checkbox"/> No			
<input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Other:	<input type="checkbox"/> Yes: List Medications and Allergic Reaction below:			
KIDNEY: <input type="checkbox"/> No Problems <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Dialysis				
<input type="checkbox"/> Other:				
NEUROLOGIC: <input type="checkbox"/> No Problems <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	Allergic to Latex? (i.e. Rubber gloves) <input type="checkbox"/> No <input type="checkbox"/> Yes			
<input type="checkbox"/> Stroke <input type="checkbox"/> TIA <input type="checkbox"/> Paralysis/Weakness/Muscular Dystrophy				
<input type="checkbox"/> Seizures <input type="checkbox"/> Bipolar <input type="checkbox"/> Schizophrenia	Allergic to Eggs, Soy, Avocado, Banana, Kiwi, or Chestnuts? <input type="checkbox"/> No <input type="checkbox"/> Yes- specify:			
<input type="checkbox"/> Creutzfeldt-Jacob Disease				
<input type="checkbox"/> Learning Disorder-Specify				
<input type="checkbox"/> Other:	Do you have any special concerns/needs regarding your visit in order for us to better take care of you?			
METABOLIC: <input type="checkbox"/> No Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid				
<input type="checkbox"/> Hepatitis/Jaundice <input type="checkbox"/> Malignant Hyperthermia				
	Patient Signature:			
BLOOD: <input type="checkbox"/> No Problems <input type="checkbox"/> Easy Bleeding/Bruising	Date:			
<input type="checkbox"/> Anemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Hemophilia <input type="checkbox"/> HIV-AIDS				
<input type="checkbox"/> Phlebitis <input type="checkbox"/> Blood Clots <input type="checkbox"/> Other:	RN Signature:			
	Date:			
HABITS: <input type="checkbox"/> Smoking _____ Packs/Day X _____ Years	ANESTHESIOLOGIST USE ONLY			
<input type="checkbox"/> Alcohol: <input type="checkbox"/> None <input type="checkbox"/> Occasional	Airway Evaluation:			
_____ Drinks/Day or _____ Drinks/Week	Mallampati Classification: 1 2 3 4			
Drugs: <input type="checkbox"/> None <input type="checkbox"/> Yes-specify:	Head Tilt: <input type="checkbox"/> WNL <input type="checkbox"/> Limited <input type="checkbox"/> Poor			
	Chin-Larynx: <input type="checkbox"/> WNL <input type="checkbox"/> ≤ 6 cm.			
PREGNANCY: Date of last period: _____	TMJ Mobility: <input type="checkbox"/> WNL <input type="checkbox"/> Limited			
Are you or could you be pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	Maxillary Arch: <input type="checkbox"/> WNL <input type="checkbox"/> High/Narrow			
	Teeth: <input type="checkbox"/> WNL <input type="checkbox"/> Chipped <input type="checkbox"/> Bridges/Caps <input type="checkbox"/> Dentures			
Any assistive devices used? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Other			
<input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheel Chair <input type="checkbox"/> Other:	NPO Status: Solids: _____ Liquids: _____			
Last Hospitalization:	ASA Class: 1 2 3 4 E			
Hospital Name, Reason for admission, and Date:	Anesthesia Plan: <input type="checkbox"/> General <input type="checkbox"/> MAC <input type="checkbox"/> Regional			
Other medical illnesses that you are being treated for	Anesthesiologist Signature:			
	Date:			
	Time:			