|  |  |
| --- | --- |
|  | **Preoperative Questionnaire****Same Day Services 509.336.7570** |
|  |
| **Patient Information** |
| Preferred Name: |  | Date of Birth: |  |
| Procedure: |  | Primary Language: |  |
| Caregiver(s): |  |
| Contact Number(s): |  |
|  |  |  |  |
| **Neurological Problems** |
| [ ]  Mini-Strokes (TIA) | [ ]  Short-term Memory Loss | [ ]  Long-term Memory Loss |
| [ ]  Fainting | [ ]  Paralysis | [ ]  Dementia |
| [ ]  Numbness/Tingling | [ ]  Parkinson’s | [ ]  Dizziness |
| [ ]  Alzheimer’s | [ ]  Headaches/Migraines | [ ]  Weakness |
| [ ]  Seizures | [ ]  Head Injury |  |
| *Neurological Comments:* |  |
|  |
|  |  |  |
| **Respiratory Problems** |
| [ ]  Asthma | [ ]  Pneumonia | [ ]  Snoring |
| [ ]  COPD | [ ]  Emphysema | [ ]  Chronic Respiratory Problems |
| [ ]  Sleep Apnea | [ ]  CPAP/BiPAP | [ ]  Bronchitis |
| [ ]  Tuberculosis | [ ]  Shortness of Breath |  |
| *Respiratory Comments:* |  |
|  |
|  |  |  |
| **Cardiac Problems** |
| [ ]  High Blood Pressure | [ ]  Congestive Heart Failure | [ ]  Heart Valve Problems |
| [ ]  Low Blood Pressure | [ ]  Coronary Artery Disease | [ ]  Atrial Fibrillation |
| [ ]  Chest Pain/Pressure | [ ]  Irregular Heartbeat | [ ]  Heart Murmur |
| [ ]  Heart Attack (MI) | [ ]  Stents | [ ]  High Cholesterol |
| [ ]  Defibrillator/Pacemaker | [ ]  Open Heart Surgery (ABG) |  |
| *Cardiac Comments:* |  |
|  |
|  |  |  |

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| --- |
| **Vascular Problems** |
| [ ]  Bleed Easily | [ ]  Varicose Veins | [ ]  Clotting Issues |
| [ ]  Poor Circulation | [ ]  Bruise Easily | [ ]  Swelling (Edema) |
| [ ]  Anemia | [ ]  Blood Clots (PE, DVT) |  |
| Do you have any Blood Pressure and/or IV Restrictions? | [ ]  No [ ]  Yes | Explain: |  |
| *Vascular Comments:* |  |
|  |
| **Endocrine Problems** |
| [ ]  Hypothyroidism | [ ]  Hyperthyroidism | [ ]  Pre-Diabetes |
| [ ]  Type 1 Diabetes | [ ]  Type 2 Diabetes | [ ]  Other: |  |
| [ ]  Hypoglycemia | [ ]  Ears, Eyes, Nose, or Throat Problems: |  |
| *Endocrine Comments:* |  |
|  |
|  |  |  |
| **Musculoskeletal Problems** |
| [ ]  Neck Pain | [ ]  Arthritis | [ ]  Jaw Problems/TMJ |
| [ ]  Osteoporosis | [ ]  Joint Issues | [ ]  Back Pain |
| [ ]  History of Broken Bones |  |  |
| *Musculoskeletal Comments:* |  |
|  |
|  |  |  |
| **Gastrointestinal Problems** |
| [ ]  Ulcers | [ ]  Diarrhea | [ ]  Gallbladder |
| [ ]  Acid Reflux | [ ]  Vomiting | [ ]  Constipation |
| [ ]  Heartburn | [ ]  Cirrhosis | [ ]  Bloody Stools |
| [ ]  Hiatal Hernia | [ ]  Jaundice | [ ]  Abdominal Pain |
| [ ]  Hernia | [ ]  Hepatitis | [ ]  Ostomy |
| [ ]  Nausea |  |  |
| *Gastrointestinal Comments:* |  |
|  |
|  |  |  |
| **Genitourinary Problems** |
| [ ]  Acute Kidney Failure | [ ]  Kidney/Bladder Infections | [ ]  Self-Catheterization |
| [ ]  Chronic Kidney Failure  | [ ]  Gynecological Problems | [ ]  Urostomy |
| [ ]  Frequent Urination | [ ]  Prostate Problems (BPH) | [ ]  Dialysis |
| [ ]  Kidney Stones | [ ]  Incontinence | [ ]  Sexually Transmitted Disease |
| Known or Possible Pregnancy at this time? | [ ]  No [ ]  Yes | *If Yes, how many weeks?* |  |
| *If No, have you gone through menopause, had a hysterectomy, or tubal ligation?* | [ ]  No [ ]  Yes |
| *Genitourinary Comments:* |  |
|  |
| **Other Problems** |
| Current or Past Cancer and Treatments: (Please Describe) |  |
|  |
| Do you have any metal or implants in your body? (Please Describe) |  |
|  |
| Current skin/healing issues, rashes, cuts, or bruises: (Please Describe) |  |
|  |
| Do you have any emotional or psychosocial diagnosis? (Depression, anxiety, PTSD, etc) |  |
|  |
| Do you feel concerned for your safety at home? | [ ]  No [ ]  Yes |
| Any specific cultural, spiritual, or religious needs that may affect your care? |  |
| Please select any of the following that you use or have. |  |
| [ ]  Cane | [ ]  Braces | [ ]  Deaf | [ ]  Glasses |
| [ ]  Crutches | [ ]  Chipped Teeth | [ ]  Read Lips | [ ]  Contacts |
| [ ]  Walker | [ ]  Lower Dentures | [ ]  Hearing Aids [ ]  L [ ]  R | [ ]  Artificial Eye  | [ ]  L [ ]  R |
| [ ]  Wheelchair | [ ]  Upper Dentures | [ ]  Hard of Hearing | [ ]  Blind Eye  | [ ]  L [ ]  R |
|  | [ ]  Partial Dentures |  | [ ]  Poor Vision  | [ ]  L [ ]  R |
|  | [ ]  No Teeth |  |  |
| Previous Hospitalizations/Surgeries (Please Include Date If Possible) |
|  |
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|  |
| Have you ever had a Blood Transfusion? |
| [ ]  No [ ]  Yes | When: |  | Reaction: |  |
| Do you object to a Blood Transfusion if needed in an emergency? | [ ]  No [ ]  Yes |
| Have you ever had a reaction to anesthesia? |
| [ ]  No [ ]  Yes | If Yes, please describe: |  |
| Do any blood relatives have a reaction to anesthesia? | Do you have a history of motion sickness? |
| [ ]  No [ ]  Yes | [ ]  No [ ]  Yes |
| Any recent exposure to a contagious disease? | Any exposure to second-hand smoke? |
| [ ]  No [ ]  Yes | [ ]  No [ ]  Yes |
| Do you, or have you ever, smoked tobacco? |
| [ ]  No [ ]  Yes | How much? |  | How long? |  | When did you quit? |  |
| Do you, or have you ever, used chewing tobacco? |
| [ ]  No [ ]  Yes | How much? |  | How long? |  | When did you quit? |  |
| Do you drink caffeinated beverages? |
| [ ]  No [ ]  Yes | How much? |  | What Type? |  | How Often? |  |
| Do you drink alcohol? |
| [ ]  No [ ]  Yes | How much? |  | What Type? |  | How Often? |  |
| Do you, or have you ever, used recreational drugs, including marijuana? |
| [ ]  No [ ]  Yes | How much? |  | What Type? |  | How Often? |  |
| Do you have an Advanced Directive or Living Will? |
| [ ]  No [ ]  Yes |  |
| If Yes, can you provide a copy? | [ ]  No [ ]  Yes | If No, would you like information? | [ ]  No [ ]  Yes |
| Is there anyone who knows your wishes regarding end of life care? | [ ]  No [ ]  Yes If yes, who? \_\_\_\_\_\_\_\_\_\_\_ |
| Do you have a POLST form? | Are you an organ donor? |
| [ ]  No [ ]  Yes |  | [ ]  No [ ]  Yes |
| Have you been outside the US in the last 30 days? | Have you recently had a fever? |
| [ ]  No [ ]  Yes |  | [ ]  No [ ]  Yes |
| Have you ever had a MDRO such as MRSA/VRE? | Have you had a pneumonia vaccine? |
| [ ]  No [ ]  Yes | When? |  |  | [ ]  No [ ]  Yes | When? |  |
| Have you had the flu vaccine this season? | Preferred Pharmacy and Location: |
| [ ]  No [ ]  Yes | When? |  |  |  |
|  |  |
| **Allergies** |
| Allergy | Reaction | Allergy | Reaction |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Current Medications** |
| Medication | Dose | Frequency | Last Taken |
|  |  |  |  |
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