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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | **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:* | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Musculoskeletal Problems** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neck Pain | | | | | | | | | | | | | | | Arthritis | | | | | | | | | | | | | | | | | | | | | | | Jaw Problems/TMJ | | | | | | | | | | | | | | | | | | | |
| Osteoporosis | | | | | | | | | | | | | | | Joint Issues | | | | | | | | | | | | | | | | | | | | | | | Back Pain | | | | | | | | | | | | | | | | | | | |
| History of Broken Bones | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| *Musculoskeletal Comments:* | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Gastrointestinal Problems** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ulcers | | | | | | | | | | | | | | | Diarrhea | | | | | | | | | | | | | | | | | | | | | | | Gallbladder | | | | | | | | | | | | | | | | | | | |
| Acid Reflux | | | | | | | | | | | | | | | Vomiting | | | | | | | | | | | | | | | | | | | | | | | Constipation | | | | | | | | | | | | | | | | | | | |
| Heartburn | | | | | | | | | | | | | | | Cirrhosis | | | | | | | | | | | | | | | | | | | | | | | Bloody Stools | | | | | | | | | | | | | | | | | | | |
| Hiatal Hernia | | | | | | | | | | | | | | | Jaundice | | | | | | | | | | | | | | | | | | | | | | | Abdominal Pain | | | | | | | | | | | | | | | | | | | |
| Hernia | | | | | | | | | | | | | | | Hepatitis | | | | | | | | | | | | | | | | | | | | | | | Ostomy | | | | | | | | | | | | | | | | | | | |
| Nausea | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| *Gastrointestinal Comments:* | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Do you have any metal or implants in your body? (Please Describe) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current skin/healing issues, rashes, cuts, or bruises: (Please Describe) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | | | |
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| **Current Medications** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medication | | | | | | | | | Dose | | | | | | | | | | | | Frequency | | | | | | | | | | | | | | | | | | | | | | | | | | | Last Taken | | | | | | | | | |
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