NewYork-Presbyterian
The University Hospital of Columbia and Cornell

50705

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

GENERAL PATIENT INFORMATION: (To be completed by Patient, Guardian or Admitting Nurses)

Name:_____

Fluent in English: ☐ Yes ☐ No Language Spoken: _____ Translator needed: ☐ Yes ☐ No

Age: _____ Sex: _____ Date of Birth: ____/____/____

Surgeon Name: _____ Expected Date of Surgery ____/____/____

Primary Care Physician: _____

Primary Care Physician's Phone No. (____) _____

Cardiologists Name _____ Phone No.: (____) _____

Expected Procedure: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Telephone Number to be Reached Prior to Surgery: _____

Best time to call: ☐ Afternoon ☐ Evening May we leave a message? ☐ Yes ☐ No

Do you have allergies? ☐ Yes ☐ No ☐ FOOD ☐ DRUG ☐ LATEX ☐ OTHER _____

ALLERGEN	REACTION

LIST PRIOR SURGERY	DATE	LIST ANY COMPLICATIONS
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

What previous Anesthesia have you had?

☐ General ☐ Regional ☐ Spinal ☐ Epidural ☐ Local ☐ None ☐ Unsure

Please list any complications/problems experienced with anesthesia.

_____

_____

_____

Please list prior Hospitalizations including Emergency Department visits

_____

_____

_____

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	PATIENT ONLY		CLINICIAN USE ONLY	
Heart: Do you have or ever had the following:	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
1) Atrial fibrillation or irregular heartbeat?			EKG	*
2) High blood pressure or Mitral Valve Prolapse?			EKG	
3) A heart attack, angina, or chest pain?			CBC, EKG	*
4) A heart murmur, heart failure or heart surgery?			CBC, EKG	*
5) High cholesterol?				
6) Chest pain or shortness of breath when climbing a flight of stairs?			EKG	*
7) A catheterization of your heart? If so, ... Date ____/____/____ Where _____			CBC, EKG	*
8) A heart stress test? If so, ... Date ____/____/____ Where _____			CBC, EKG	
Do you:				
9) Take antibiotics prior to a surgical procedure or dental work?				
10) Do you have a pacemaker or implantable defibrillator (AICD)? If yes, manufacturer: (check one) ☐ Medtronic ☐ Guidant ☐ St. Jude ☐ Biotronik ☐ Other Date ____/____/____ Where _____ ***Ask your cardiologist to send the most recent pacemaker interrogation to the surgeon and please bring your information card with you on the day of surgery.***			EKG **If yes, contact EP specialist**	
11) Are you 60 years old or older?			EKG	
Breathing: Do you have or ever had the following:				
12) Shortness of breath with exertion or swollen ankles?			CBC, EKG	*
13) A need for more than one pillow or wake up at night short of breath?			CBC, EKG	
14) Tuberculosis (TB)?			CXR	
15) Smoked more than 1 pk/day for 20 yrs or 2 pks/day for 10 yrs?			CBC, CXR	
16) Smoked in the last year?				
17) Oxygen at home to help you breathe?			CBC, CXR	*
18) Severe emphysema, asthma or bronchitis (COPD) that limits your activities?			EKG, CXR	*
19) Did you ever have an embolus or clot go to your lung?				
Obstructive Sleep Apnea (OSA):				
20) Do you have Obstructive Sleep Apnea (OSA)?			CBC, EKG, CXR	*
21) Do you frequently snore loudly, enough to be heard through closed doors?			CBC, EKG	
22) Have you been told by others that you gasp, choke, snort, or stop breathing during your sleep?			CBC, EKG	*
23) Do you have or are you being treated for high blood pressure?			EKG	
24) Do you use a BiPAP or C-PAP machine at home? If so, settings: _____			CBC, CXR	*

* Anesthesia Consult Recommended
CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

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	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
Blood Disorders: Do you have or ever had the following:				
25) Anemia or low blood count?			CBC	
26) Bleeding ulcers or rectal bleeding?			CBC	
27) Sickle cell disease or trait?			CBC, CXR	
28) Blood clots in your legs (phlebitis) or Deep Vein Thrombosis (DVT)?				
Do you:			PT/INR	*
29) Use warfarin (Coumadin) as a blood thinner?				
30) Bruise easily and/or have a bleeding problem?			CBC, PT/INR/APTT	
Endocrine/Renal Disorders: Do you have or ever had the following:				
31) Diabetes?			BMP, EKG	
32) Adrenal or thyroid disease or tumor?			BMP	
33) Kidney disease, kidney failure or are you on dialysis?			BMP, EKG, CBC	
34) Severe hepatitis, jaundice, cirrhosis or liver failure?			LIV, PT, INR, APPT	
35) Do you use diuretics (water pills), digoxin (Lanoxin) or steroids (Prednisone)?			BMP, EKG	
Gastrointestinal: Do you have or ever had the following:				
36) Severe abdominal pain?				
37) Loss of appetite or unintentional weight loss in the past year?				
38) Acid reflux?				
Neurological/Musculo/Skeletal: Do you have or ever had the following:				
39) Stroke or seizures?			BMP, EKG, CBC	
40) Weakness in your arms or legs?				
41) Head, neck or back injuries?				
42) Chronic pain?				
43) "Pins and needles" or loss of sensation in your arms or legs?				
44) "Collagen disease", Lupus, Rheumatoid arthritis, or Raynaud's disease?				
Obstetrics				
45) Are you or do you believe you might be pregnant?			BHCG	
Last menstrual cycle _____.			If yes to (#45 & #46) a blood specimen must be sent < 72 hours of surgery for T & S and T & C	
46) Have you been pregnant in the last 3 months?				
Cancer: Do you have or ever had the following:				
47) Cancer and/or received chemotherapy?			CBC	
48) Have you received radiation therapy?			CXR, EKG, CBC	
49) An axillary lymph node dissection (under arm): ☐ Yes ☐ No				
Which side: _____				

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Anesthesia Related Issues: Have you had:	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
50) Problems with placement of a breathing tube in your windpipe (trachea) for surgery?				*
51) Surgery on your throat, vocal cords or lungs?				*
52) Any bad reactions to anesthesia in you or your relatives?				*
53) A history of Malignant Hyperthermia in you or any of your relatives?				*
54) Do you have trouble opening your mouth or bending your neck forward or backward?				*
55) Are you having Bariatric (weight loss), Vascular or Thoracic Surgery (chest)?				*
You will see YOUR anesthesiologist on the day of surgery. In addition,				
56) Do you want to see a screening Anesthesiologist before the day of Surgery?				*
Communicable Disease: Do you have or ever had the following:				
57) ☐ HERPES ☐ AIDS ☐ HIV				
58) Contact within the last month with anyone suspected of having SARS?				
59) Have you traveled outside of the U.S. in the last month? If yes, where? _____				
Eyes: Do you have or had the following:				
60) Dry eyes?				
61) Glaucoma or cataracts?				
Behavioral Health				
62) Have you suffered from anxiety, depression, or a psychiatric disorder?				
Blood Transfusion: Do you have or had the following:				
63) Blood transfusion in the last 3 months?			If yes to (#63) a blood specimen must be sent < 72 hours prior to surgery for T&S and T&C	
64) A reaction or allergy to a blood transfusion?				
65) Did you donate blood for this surgery?				
66) Did a family member donate blood?				

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LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

Patient/Guardian Signature _____ Date: ____/____/_____ Time: _____ AM/PM

If completed by the RN: _____ RN Date: ____/____/_____ Time: _____ AM/PM
Nurses Signature