

THE CENTER FOR OUTPATIENT MEDICINE, LLC
PATIENT PRE-ANESTHESIA/SURGERY QUESTIONNAIRE

Name: _____ Home Phone: _____ Work Phone _____
 Surgeon: _____ Medical Doctor: _____ Surgery date: _____
 Height: _____ Weight: _____ Age: _____ Birthdate: _____

List any allergies to medication, latex, or rubber :

NONE

List any previous surgeries, type and year:

Surgical /AnestheticComplications:

Nausea YES NO

Vomiting YES NO

Bleeding YES NO

Family history of anesthetic problems?

YES

NO

NONE

DO YOU HAVE, OR HAVE YOU EVER HAD:

PROBLEM	YES	NO	PROBLEM	YES	NO
Frequent Shortness of Breath?----- (Circle one) Mild / Moderate / Severe	<input type="checkbox"/>	<input type="checkbox"/>	Leaky Heart Valve, Heart Murmur-----	<input type="checkbox"/>	<input type="checkbox"/>
Asthma-----	<input type="checkbox"/>	<input type="checkbox"/>	Stroke, CVA, TIA-----	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema-----	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder-----	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis-----	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease-----	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough-----	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis-----	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea-----	<input type="checkbox"/>	<input type="checkbox"/>	Myasthenia Gravis-----	<input type="checkbox"/>	<input type="checkbox"/>
CPAP?-----	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease (Hepatitis, Cirrhosis)-----	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Snoring-----	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis-----	<input type="checkbox"/>	<input type="checkbox"/>
Recent Respiratory Infection-----	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems/Depression-----	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems-----	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems-----	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes-----	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain/ Problems-----	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure-----	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease-----	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack-----	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (Type _____)	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease-----	<input type="checkbox"/>	<input type="checkbox"/>	TMJ or Jaw Problems-----	<input type="checkbox"/>	<input type="checkbox"/>
Angina-----	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux/Frequent Heartburn-----	<input type="checkbox"/>	<input type="checkbox"/>
Fast or Irregular Heart Beats-----	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer-----	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure-----	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia-----	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker (Date Placed _____)--	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease, Anemia-----	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse-----	<input type="checkbox"/>	<input type="checkbox"/>	Motion Sickness-----	<input type="checkbox"/>	<input type="checkbox"/>
			Any other medical condition?-----	<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" Answers:

YES NO Question

YES	NO	Question
<input type="checkbox"/>	<input type="checkbox"/>	Any history of smoking? How much daily? _____ How many years? _____ Quit? _____ When? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol? How much? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you use any street drugs? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures? (Circle) LOWER UPPER PARTIAL
<input type="checkbox"/>	<input type="checkbox"/>	Do you have capped front teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been hospitalized in the last 3 months? Reason _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been treated for an antibiotic resistant infection? <input type="checkbox"/> YES
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed with tuberculosis? If yes, when _____? Are you currently being treated? <input type="checkbox"/> NO
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed with an infectious disease? If yes, when _____?
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently been exposed to an infectious disease? If yes, when _____?

FEMALE PATIENTS : Last Period: _____

Post menopausal greater than 2 years
 Hysterectomy Tubal Ligation Lactating

MALE PATIENTS:

Do you wear a beard? YES NO

ALL PATIENTS: You will meet the anesthesiologist the day of surgery.

Do you want to set up an appointment to meet an anesthesiologist to the day of surgery? YES NO

Do you have questions about any of the following:	Do you have any of the following which may impact your learning or care?	Comments/Explanations
None	None	
Medication	Cognitive Impairment	
Procedure/Surgery	Hearing Limitations	
Pain Management	Visual Limitations	
Wound Care	Physical Limitations	
	Speech/Language	
	Cultural/Religious Beliefs	

Do you have an advanced directive? Yes No (If "yes" please provide a copy upon registration or admission.)

Who filled out this form? SELF Other _____

Patient or Responsible Adult Signature: _____ Date: _____

May we leave a message at your home, if needed, to discuss your procedure? Yes No

FOR TCOM USE ONLY

Surgery #1 Reviewed by: RN _____ Date _____ SURGEON _____ Date _____
 Surgery #2 Reviewed by: RN _____ Date _____ SURGEON _____ Date _____

PRETESTING: Date: _____ Time: _____ Pulse _____ Resp _____ BP _____ SpO2 on RA _____
 BMI _____
 _____ RN
 Pre-tests done today: BMP/CMP CBC EKG CXR Anesthesia Appointment Other: _____

TYPE OF ANESTHESIA REQUESTED: Surgery #1 _____ Surgery #2 _____

ANESTHESIA NOTES: _____

Mental status: Alert & Oriented X 3 <input type="checkbox"/> CV: RR/ no murmur, gallop <input type="checkbox"/> Lungs: CTA <input type="checkbox"/> A/W: mallampati I II III IV TEETH OK <input type="checkbox"/> ANTERIOR CAPS <input type="checkbox"/> TMJ MOBILITY WNL <input type="checkbox"/> DECREASED <input type="checkbox"/> NECK EXTENSION WNL <input type="checkbox"/> DECREASED <input type="checkbox"/> BEARD <input type="checkbox"/> TMD DECREASED <input type="checkbox"/> PREDICTED DIFFICULT AIRWAY <input type="checkbox"/>	DIAGNOSTIC STUDIES EKG: Chemistries: Other:
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SURGERY #1 _____ _____ _____ ASA physical status: 1 2 3 4 E Anesthetic plan: <input type="checkbox"/> GA <input type="checkbox"/> MAC <input type="checkbox"/> IVB <input type="checkbox"/> Peripheral block <input type="checkbox"/> SAB <input type="checkbox"/> Peripheral block for pain control <input type="checkbox"/> Physical Exam Unchanged from Surgery #1 _____ MD/DO	SURGERY #2 _____ _____ _____ ASA Physical Status: 1 2 3 4 E Anesthetic plan: <input type="checkbox"/> GA <input type="checkbox"/> MAC <input type="checkbox"/> IVB <input type="checkbox"/> Peripheral Block <input type="checkbox"/> SAB <input type="checkbox"/> Peripheral block for pain control <input type="checkbox"/> Physical Exam Unchanged from Surgery #1 _____ MD/DO
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