STERLING
SURGICAL HOSPITAL
The Surgery You Need in the Setting You Want

PATIENT LABEL

PRE-OPERATIVE QUESTIONNAIRE

GENERAL INFORMATION

① **Patient Name:** _____

② **Date of Birth:** ____ / ____ / _____

③ **Height:** _____ ' _____ "

④ **Weight:** _____ lbs

⑤ **Procedure Scheduled:** _____

_____

_____

⑥ **Date of Procedure:** ____ / ____ / _____

⑦ **Please list all home Medications, including: Prescriptions, Herbal, and Over-the-Counter Medications.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

⑧ **Drug/Medication Allergies:** _____

_____

_____

_____

_____

_____

⑨ **Food Allergies:** _____

_____

_____

_____

_____

_____

⑩ **Vaccinations:**

Date of Last Flu Vaccination: _____

Date of Last Pneumonia Vaccination: _____

⑪ **Do you use/wear any of the below:**

Glasses	❑ Yes	❑ No
Contacts	❑ Yes	❑ No
Dentures	❑ Yes	❑ No
Removable bridges	❑ Yes	❑ No
Hearing aids	❑ Yes	❑ No

⑫ **Current complaints of pain?** ❑ Yes ❑ No

If yes, Description of Pain: _____

_____

_____

_____

SEE PAGES 2-4 FOR MEDICAL HISTORY

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MEDICAL HISTORY PART I

① Neurological:

Stroke	❑ Yes	❑ No
TIA	❑ Yes	❑ No
Dementia / Alzheimer's	❑ Yes	❑ No
Parkinson's	❑ Yes	❑ No
Seizures / Epilepsy	❑ Yes	❑ No
Spinal Cord Injury	❑ Yes	❑ No
Head Trauma	❑ Yes	❑ No
Brain Injury	❑ Yes	❑ No
Headaches	❑ Yes	❑ No
Numbness	❑ Yes	❑ No
Weakness	❑ Yes	❑ No

Additional Details: _____

_____

Other: _____

MD: _____

② Respiratory

COPD / Emphysema	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Bronchitis	❑ Yes	❑ No
Pneumonia	❑ Yes	❑ No
Lung Disease	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Pulmonary Embolism	❑ Yes	❑ No
Oxygen Use	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Inhaler Use	❑ Yes	❑ No
Breathing Treatments	❑ Yes	❑ No
Sleep Apnea	❑ Yes	❑ No
Bipap Machine (sleep apnea)	❑ Yes	❑ No
Smoker	❑ Yes	❑ No
Smoke Exposure	❑ Yes	❑ No
Tobacco Use	❑ Yes	❑ No
Recent Cough	❑ Yes	❑ No
Productive Cough	❑ Yes	❑ No

Additional Details: _____

_____

Other: _____

MD: _____

③ Cardiac:

Heart Attack	❑ Yes	❑ No
Angina/Chest Pain	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Coronary Artery Disease	❑ Yes	❑ No
Aneurysm	❑ Yes	❑ No
Blood Clots	❑ Yes	❑ No
Peripheral Vascular Disease	❑ Yes	❑ No
Congestive Heart Failure	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No
Internal Defibrillator	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No
Irregular Heart Beat	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Low Blood Pressure	❑ Yes	❑ No
Stents	❑ Yes	❑ No

Additional Details: _____

_____

Other: _____

MD: _____

④ Musculoskeletal (Muscles, Bones):

Arthritis	❑ Yes	❑ No
Rheumatoid Arthritis	❑ Yes	❑ No
Osteoporosis	❑ Yes	❑ No
Gout	❑ Yes	❑ No
Fractures	❑ Yes	❑ No
Amputation	❑ Yes	❑ No
Fibromyalgia	❑ Yes	❑ No
Muscle Disorders	❑ Yes	❑ No
Musculoskeletal Trauma/Deformity	❑ Yes	❑ No
Back Pain	❑ Yes	❑ No
Neck Pain	❑ Yes	❑ No
Use of Cane, Walker, Crutches	❑ Yes	❑ No
History of Falls	❑ Yes	❑ No

Additional Details: _____

_____

Other: _____

MD: _____

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PRE-OPERATIVE QUESTIONNAIRE

MEDICAL HISTORY PART I Continued

⑤ Eyes, Nose, Ears & Throat/Endocrine:

Cataracts	❑ Yes	❑ No
Eye Problems	❑ Yes	❑ No
Eye Infections/Injury	❑ Yes	❑ No
Ear Infections/Injury	❑ Yes	❑ No
Sinus Problems	❑ Yes	❑ No
Difficulty Swallowing	❑ Yes	❑ No
Oral Bleeding	❑ Yes	❑ No
Dental Problems	❑ Yes	❑ No
Sore Throat (presently)	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Hypoglycemia	❑ Yes	❑ No
Thyroid Disease	❑ Yes	❑ No
Hormone Disorders	❑ Yes	❑ No
Lupus	❑ Yes	❑ No
Autoimmune Disease	❑ Yes	❑ No
Steroid Therapy	❑ Yes	❑ No
Hormone Therapy	❑ Yes	❑ No

Additional Details: _____

_____

Other: _____

MD: _____

⑥ Blood Disorders:

Cancer	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Leukemia	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No
Sickle Cell	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No
Radiation	❑ Yes	❑ No
Unexplained Bleeding	❑ Yes	❑ No
Blood Transfusion (if yes, date)	❑ Yes	❑ No

Additional Details: _____

_____

Other: _____

MD: _____

⑦ Gastrointestinal:

Hepatitis	❑ Yes	❑ No
Liver Problems	❑ Yes	❑ No
Ulcers	❑ Yes	❑ No
Heartburn	❑ Yes	❑ No
Hiatal Hernia	❑ Yes	❑ No
Nausea	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Reflux	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Abdominal Pain	❑ Yes	❑ No
Bowel Problems	❑ Yes	❑ No
Colostomy/Ileostomy	❑ Yes	❑ No
Hemorrhoids	❑ Yes	❑ No
Celiac Disease	❑ Yes	❑ No
Pancreatitis	❑ Yes	❑ No
Bleeding from GI Tract	❑ Yes	❑ No
Changes in Weight	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No
Kidney Stones	❑ Yes	❑ No
Urinary Tract Infection	❑ Yes	❑ No
Dialysis	❑ Yes	❑ No
Bladder Problems	❑ Yes	❑ No
Incontinence	❑ Yes	❑ No
Urination Problems	❑ Yes	❑ No
Prostate Problems	❑ Yes	❑ No
Hernias	❑ Yes	❑ No

Additional Details: _____

_____

Other: _____

MD: _____

⑧ Reproductive:

History of Reproductive Disorder	❑ Yes	❑ No
Are you currently pregnant?	❑ Yes	❑ No
STDs	❑ Yes	❑ No

Last Menstrual Period (date): _____

Additional Details: _____

_____

Other: _____

MD: _____

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MEDICAL HISTORY PART I Continued

⑨ **Psychiatric / Social:**

Depression	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No
Psychiatric Problems	❑ Yes	❑ No
Alcohol Use	❑ Yes	❑ No
Substance /Drug Use	❑ Yes	❑ No
Caffeine Use	❑ Yes	❑ No
Job Loss	❑ Yes	❑ No
Sleep Difficulties	❑ Yes	❑ No
Recent Stress or Loss	❑ Yes	❑ No

Additional Details: _____

_____

Other: _____

MD: _____

MEDICAL HISTORY PART II

Please check the Not Applicable (N/A) box if any of the following questions do not apply to you.

① Previous Hospitalizations (and dates): ❑ N/A

_____

_____

_____

_____

_____

_____

_____

② Previous Surgeries (and dates): ❑ N/A

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_____

③ Anesthesia Reactions/Complications: ❑ N/A

_____

_____

_____

④ Anesthesia Reactions/Complications (in your family) : ❑ N/A

_____

_____

_____

⑤ Have you had fever recently? ❑ Yes ❑ No

⑥ Have you had any recent acute infections? ❑ Yes ❑ No

⑦ Have you ever had MRSA? ❑ Yes ❑ No

⑧ Do you have any skin problems? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

⑨ Are you on any special diet? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

X _____

Patient Signature

Date: _____/_____/_____ Time: _____

X _____

Nurse Signature

Date: _____/_____/_____ Time: _____