Redington-Fairview General Hospital

Patient Pre-operative Questionnaire

Please answer all questions and bring form with you when you come to the hospital for your pre-procedure interview.

Addressograph

Name:________________________ Phone #: Home:___________ Work:___________ Cell:___________

Date of Birth:_____________ Height:________ Weight:________

Do you smoke? ☐ Yes ☐ No How much? __________

Do you smoke marijuana? ☐ Yes ☐ No How much? __________

Do you take recreational drugs? ☐ Yes ☐ No What kind? ______________________

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? _____ Week? _____

Have you ever had a problem with anesthesia after surgery? ☐ Yes ☐ No

If yes, please circle the kind of problem: muscle soreness, significant sore throat, nausea, other ____________

Has anyone in your family ever had a serious problem during anesthesia or surgery? ☐ Yes ☐ No

If yes, who and what kind of problem? ____

Have you ever been told that you have Sleep Apnea? ☐ Yes ☐ No

Do you use a CPAP or BiPAP? ☐ Yes ☐ No Do you use oxygen? ☐ Yes - liter flow _____ ☐ No

Can you climb a flight of stairs without having shortness of breath? ☐ Yes ☐ No

Circle any of the following conditions that you have now or have had in the past.

Heart Disease
Heart Attack
High Blood Pressure
Heart Murmur
Heart Valve Disease
Rheumatic or Scarlet Fever
High Cholesterol
Cardiac Pacemaker or Defibrillator
Stroke
COPD
Emphysema
Shortness of Breath
Asthma
Diabetes
Thyroid Disease
Kidney Disease or Stones
Ulcers
Hiatal Hernia
Acid Reflux
Glaucoma
Motion Sickness
AIDS
Hepatitis (which kind)
Liver Disease

Hemophilia
Bleeding Disorder
Epilepsy or Seizures
Sickle Cell Disease
Porphyria
Drug Addiction
Alcohol Addiction
Depression
Anxiety Disorder
Bipolar
Schizophrenia

Women: Are you pregnant now? ☐ Yes ☐ No
Last menstrual period___________

Any other disease that you are in treatment for: ______________________

Please list all surgeries that you have had and the year you had the surgery:

____

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____

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REDINGTON FAIRVIEW GENERAL HOSPITAL **MR#**___________________________

Name of your Pharmacy:_____________________________________
Allergies/Type of Reaction: ____
____

Latex Allergy ☐ Yes ☐ No
Are you on a blood thinner? ☐ Yes ☐ No
Do you get any treatments or injections (chemotherapy, blood or iron infusions, methadone, etc.) at a clinic?
☐ Yes ☐ No If yes, please list: ___________________________________

Diet/Drug/Herbal/Over the counter medications	Dose	How often?	Route	For RN use only
DIET:				

If you answer Yes to any of the following, please write name and dosage.

YES	NO	List	Medication Name/Dosage
		Aspirin	
		Warfarin, Coumadin	
		Medical Marijuana	
		Eye Drops	
		Ear Drops	
		Nose Drops/Sprays	
		Inhalers	
		Med Creams/Ointment	
		Med Patches	
		Suppositories/Cream	
		Vitamins	
		Dietary Supplements	
		Herbals	
		Green Tea/Specialty Tea	
		Homeopathic Meds	

To the best of my knowledge, all the above answers are true and correct. If I have any changes in my health or my medications, I will inform the anesthesia department before my surgery.

Date________________Signature_____________________________________(patient, parent, legal guardian)