



ASCREENCRIT

Surgical Anesthesia Preoperative Questionnaire

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Patient Name _____

MRN _____

PATIENT IDENTIFICATION LABEL

Date: _____

DOS: _____

Do you currently have, or have a history of any of the following? Please check box if yes.

***If any bold items are marked, patient SHOULD be seen in Anesthesia Pre-op Clinic for evaluation.**

Cardiovascular

Cardiologist: _____

- ☐ **Pacemaker/Defibrillator**
Type? _____
Date last interrogated? _____
- ☐ Heart Attack
 - ☐ **Less than 12 months ago**
- ☐ **A-Fib or other abnormal heart rhythm**
- ☐ **Heart transplant**
- ☐ Heart Surgery/Stents
 - ☐ **Less than 12 months ago**
- ☐ **Chest Pain**
- ☐ High Blood Pressure
- ☐ **Shortness of breath when walking 2-3 blocks**
of blocks can you walk _____
of flights of stairs you can climb _____
- ☐ **Heart Disease/Coronary Artery Disease**
- ☐ **Congestive Heart Failure/CHF**
- ☐ **Ventricular Assist Device/VAD**

Pulmonary

Pulmonologist: _____

- ☐ COPD/Emphysema/Asthma
How often do you need to use your rescue inhaler?
 - ☐ **Daily** ☐ Weekly ☐ Monthly
- ☐ **Pulmonary Hypertension**
- ☐ Sleep Apnea
 - ☐ Do you use CPAP/BiPAP?
- ☐ **Oxygen usage at home**
- ☐ Part of lung removed/resected
- ☐ **Lung transplant**

Hematologic

- ☐ **Taking blood thinners (other than aspirin)?**
- ☐ Blood clot (DVT, PE)
 - ☐ **Less than 12 months ago**
- ☐ Bleeding/clotting disorder
- ☐ HIV

Neurological

- ☐ Stroke or mini stroke/TIA
 - ☐ **Less than 12 months ago**
 - ☐ Weakness? _____
- ☐ Seizures
 - ☐ Daily ☐ Weekly ☐ Monthly

Renal/Endocrine/Gastrointestinal

Nephrologist: _____

- ☐ Kidney Problems/Failure
 - ☐ Dialysis What days? _____
- ☐ **Kidney Transplant** What year? _____
- ☐ GERD/Acid Reflux
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ **If female, is your weight >240 lbs?**
- ☐ **If male, is your weight >270 lbs?**
- ☐ Diabetes
 - ☐ Do you use insulin?

Anesthesia Problems

- ☐ **Malignant Hyperthermia**
 - ☐ **You** ☐ **Family member**
- ☐ **Have you been told you were difficult to intubate (place breathing tube)?**
- ☐ **Prolonged Sedation/Intubation**
- ☐ Awareness under Anesthesia
- ☐ Post-Operative Nausea/Vomiting
- ☐ Other _____

Miscellaneous

Family doctor: _____

- ☐ Fever >100 F within past month
- ☐ Respiratory infection/pneumonia within past month
- ☐ History of smoking or current smoker
- ☐ Alcohol use of 2 or more drinks per day
- ☐ History of marijuana, cocaine, crack, meth and/or IV drugs

Anything else important for the anesthesia team to know? _____

Signature: _____