

PATIENT PREOPERATIVE HISTORY

Name _____ DOB _____ Preferred Daytime Phone # _____

Planned surgery _____ Today's Date _____

Surgeon _____ Primary Care Physician _____ PCP Phone # _____

Please list all previous surgeries (and approximate dates)

Please list any allergies to medications, latex, food or other (and your reactions to them)

List all medications (include over-the-counter drugs, inhalers, herbals, supplements and aspirin)

Drug Name	Dose and How Often?	Drug Name	Dose and How Often?
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Weight: (lbs or kg) _____ Height: (inches or cm) _____ (Circle the measurement units you use)

Please check any of the following that apply to your health:

<input type="checkbox"/> Heart attack at any time	<input type="checkbox"/> Heart stent at any time	<input type="checkbox"/> LVAD
<input type="checkbox"/> Heart attack within past 60 days	<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Heart device
<input type="checkbox"/> Chest pain or pressure with activity	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Angina	<input type="checkbox"/> Congenital heart disease	<input type="checkbox"/> Defibrillator
<input type="checkbox"/> Heart failure	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Fainted in the last year
<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Murmur	<input type="checkbox"/> Pain in legs while walking
<input type="checkbox"/> Heart stent in the last 6 months	<input type="checkbox"/> Valve disorder	<input type="checkbox"/> None of these
<input type="checkbox"/> Unable to climb 2 flights of stairs or walking 2 blocks because of chest pain or trouble breathing		

<input type="checkbox"/> Oxygen at home	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia in last 2 months
<input type="checkbox"/> Pulmonary hypertension	<input type="checkbox"/> COPD	<input type="checkbox"/> Any problems with your lungs
<input type="checkbox"/> Trouble breathing at rest or with minimal exertions		<input type="checkbox"/> Severe cough
		<input type="checkbox"/> None of these

Name _____

<input type="checkbox"/> Face, arm or leg weakness	<input type="checkbox"/> Dementia	<input type="checkbox"/> Spinal cord injury
<input type="checkbox"/> Stroke/TIA within past 60 days	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Brain tumor
<input type="checkbox"/> Stroke or TIA at any time	<input type="checkbox"/> Myasthenia gravis	<input type="checkbox"/> Brain aneurysm or AVM
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/> Epilepsy, blackouts or seizures
<input type="checkbox"/> Difficulty speaking		<input type="checkbox"/> None of these

<input type="checkbox"/> Hospitalized in last 30 days	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Lupus
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Sickle cell disease	<input type="checkbox"/> Hepatitis B/C	<input type="checkbox"/> Scleroderma
<input type="checkbox"/> Blood transfusion in last 3 months	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Sjogren's
<input type="checkbox"/> Blood clots/ Pulmonary embolus	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Jehovah's Witness
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Use illegal drugs (excluding marijuana)
<input type="checkbox"/> Cancer: What type? _____	<input type="checkbox"/> Adrenal disorder	<input type="checkbox"/> Kidney failure
<input type="checkbox"/> Chemo or radiation last 3 months	<input type="checkbox"/> Pituitary disorder	<input type="checkbox"/> Taking antibiotics for any reason
<input type="checkbox"/> Kidney disease other than stones	<input type="checkbox"/> Dialysis	<input type="checkbox"/> None of these

<input type="checkbox"/> Blood thinners or anticoagulants other than aspirin	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Severe nose bleeds
<input type="checkbox"/> Bleeding with surgery or tooth extractions	<input type="checkbox"/> Von Willebrands	<input type="checkbox"/> None of these
	<input type="checkbox"/> Known bleeding disorder	

<input type="checkbox"/> Malignant hyperthermia (in blood relatives or self) with anesthesia	<input type="checkbox"/> Dentures
<input type="checkbox"/> Severe nausea or vomiting from anesthesia	<input type="checkbox"/> Problems opening your mouth
<input type="checkbox"/> Difficult airway with anesthesia	<input type="checkbox"/> Loose teeth
	<input type="checkbox"/> None of the these

<input type="checkbox"/> Unintentional weight loss > 10 lbs	<input type="checkbox"/> Feel that everything you did was an effort: ____ days in the last week
<input type="checkbox"/> Difficulty getting out of bed/chair by yourself	<input type="checkbox"/> Need assistance with eating or bathing or dressing
<input type="checkbox"/> Difficulty making your own meals	<input type="checkbox"/> Fallen in the last 6 months (____ times)
<input type="checkbox"/> Your physical abilities limit your daily activities	<input type="checkbox"/> None of the these
<input type="checkbox"/> Difficulty doing your own shopping	

<input type="checkbox"/> Very loud snoring	<input type="checkbox"/> High blood pressure/ Hypertension	<input type="checkbox"/> Sleep apnea; Uses CPAP
<input type="checkbox"/> Tired/fall asleep frequently during the day		<input type="checkbox"/> None of these
<input type="checkbox"/> Observed to stop breathing during sleep	<input type="checkbox"/> Sleep apnea; NO CPAP	

<input type="checkbox"/> Cannot speak and/or understand English	<input type="checkbox"/> Deaf	<input type="checkbox"/> None of these
<input type="checkbox"/> Cannot lie flat for 45 min	<input type="checkbox"/> Blind	
<input type="checkbox"/> Currently pregnant. Last menstrual period began: _____		
<input type="checkbox"/> Smoker (current or past) ____ packs/day for ____ years. Quit date _____		
<input type="checkbox"/> Drink alcohol. How much each day? ____ beers ____ glasses of wine ____ shots of hard alcohol		

Please list any medical illness or medications not noted already: