Pre-Procedure Assessment
(Adult)

Patient Label

Patient Name: _____ **Date of Birth:** _____

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Date of Procedure: _____ Surgeon: _____ Age: _____ M☐ F☐

Height: _____ Weight: _____ **BMI Score:** _____ Preferred Contact Number: _____

Procedure: _____ Left☐ Right☐ Bilateral☐ N/A☐

Allergies to metal, latex or adhesive: _____ **Please list medication allergies on the Medication form**

PAST MEDICAL HISTORY

	Have you ever had a history of the following:	YES	NO	COMMENTS
1.	You or anyone in your family had a major problem with anesthesia?			
2.	You or anyone in your family ever had malignant hyperthermia?			
3.	Sleep apnea? If yes, do you use a C-Pap machine? Where was sleep study performed:			
4.	Lung Disorders- Asthma, Emphysema, bronchitis, COPD, shortness of breath?			Bring your inhaler.
5.	Have you ever smoked? If yes, how much and how long?			
6.	Can you walk up a flight of steps without getting short of breath?			
7.	Problems turning your neck in all directions or opening your mouth?			
8.	Loose teeth or dentures?			
9.	High blood pressure?			
10.	Chest pain, heart problems, heart attack, irregular heart rhythm?			
11.	Pacemaker, defibrillator or implanted heart devices?			
12.	Diabetes? If yes, are you insulin dependent?			
13.	Heartburn, acid reflux or hiatal hernia?			
14.	Thyroid or hormone deficiencies?			
15.	Liver disease, hepatitis, kidney disease, kidney failure?			
16.	Stroke, Mini-Strokes, weakness or paralysis?			
17.	Seizure or epilepsy?			
18.	Excessive bleeding tendency or a diagnosed blood disorder?			
19.	Could you be pregnant? Last period _____			
20.	Do you drink alcohol? If yes, how often _____			
21.	Any recreational drug use? If yes, type and frequency _____			
22.	Any other medical conditions? Please list in comments.			
23.	**Previous Surgeries: Please circle all that apply.**			
	Appendix, Back, Breast, Carpal Tunnel, Cataract, Colonoscopy, Gallbladder, Gynecological, Heart bypass, Heart stents, Hernia, Knee, Hip or Shoulder surgery, Sinus surgery, Tonsils, Total joint replacement, Upper endoscopy, Vascular			
24.	Other surgeries? Please list in comments			

Notes concerning above conditions or surgeries:

_____

_____

Patient Signature: _____

Reviewed by PreOp Nurse: _____ Date: _____

Jan 2020