Preoperative Questionnaire

Dear Patient,
This questionnaire will help your anesthesia team determine if any preoperative work up will be needed prior to your surgery and help them gather all available medical information about you. Please fill it out as best you can. This information will help to avoid any delay in your surgery.

In some cases, we will contact you for a preoperative evaluation over the phone. If you have any questions, you can contact us at **505-639-4640.** Thank you!

Name: ______________________________ Date of Birth: ____________________ Age: __________

Patient Height: ______________________________ Patient Weight: __________________ BMI: __________

Phone #: ______________________________ Email: ______________________________

Surgeon: ______________________________ Date of Surgery: ______________________________

Emergency Contact name: ______________________________ Phone #: ________________________

Emergency Contact relation to the patient? ____

Name of Person completing this form: ______________________________ Relation: _______________

Do you have medical power of attorney? ☐ Yes ☐ No
Do you have advanced directives? ☐ Yes ☐ No
If yes, please attach a copy with this form.

Do you have primary care provider: ☐ Yes ☐ No

Primary care provider name: ____

Primary care provider phone number: ______________________________

Date of last visit with primary care provider: ______________________________

Have you ever been seen by Cardiologist, Pulmonologist, Nephrologist or Endocrinologist: ☐ Yes☐ No

Cardiologist Name: ______________________________ Last Visit: ____________________

Pulmonologist Name: ______________________________ Last Visit: ____________________

Nephrologist Name: ______________________________ Last Visit: ____________________

Endocrinologist Name: ______________________________ Last Visit: ____________________

Social History:

Do you have a history of illegal drug(s) use? ☐ Yes ☐ No

What drug(s): ____________________

Do you have a history of marijuana use? ☐ Yes ☐ No

How often: ____________________

Do you have a history of IV drug use? ☐ Yes ☐ No

If applicable, when did you quit? _________________________

Do/did you ever smoke? ☐ Yes ☐ No

If yes, please circle: Cigarettes, tobacco vaporizer, chewing tabaco, pipe, e-cigarette, or hookah.

How often: ____________________ **Year quit smoking**: _______________

Do you drink alcohol? ☐ Yes ☐ No **Do you have a history of Alcohol abuse?** ☐ Yes ☐ No

Do you have issues with IV's: ☐N/A ☐ Rolling veins ☐ Passing out ☐ Deep Veins ☐ other: __________________________

Do you currently have a central venous line, such as chemo and/or antibiotic port, PICC line, or dialysis catheter?
☐ Yes ☐ No

Physical Activity:

Do you have any problems with mobility (such as using a wheelchair, cane or walker, issues with balance or walking)?

☐ Yes ☐ No If yes, please describe: ____

Do you have a history of falls in the last 6 months? ☐ Yes ☐ No

Do you require assistance with activities of daily living (such as dressing, bathing, bathroom, etc.)? ☐ Yes ☐ No

The activity that most closely represents your level of physical activity is:

☐ **I am able to run 2 miles or more.**

☐ **I am able to bike 1 mile or more.**

☐ **I am able to walk 1 city block (200 Yards).**

☐ **I am able to climb 2 flights of stairs without stopping.**

☐ **I am able to climb 1 flight of stairs or less before stopping.**

☐ **I am short of breath at rest.**

☐ **Not applicable.**

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Cardiac (Heart):

Have you ever been diagnosed with any cardiac issues: ☐N/A

☐ **Heart Murmurs** ☐ **Pacemaker** ☐ **Angina (chest pain)**
☐ **Irregular Heartbeat/Rhythm** ☐ **Ablation** ☐ **Congestive Heart Failure**
☐ **AFIB** ☐ **Heart stents** ☐ **ICD (implanted cardiac defibrillator)**
☐ **Coronary Artery Disease** ☐ **Vascular Disease** ☐ **Heart Valve Issues**
☐ **High Blood pressure** ☐ **CABG/Bypass** ☐ **Holter Monitor**
☐ **Heart Attack** ☐ **High Cholesterol or Lipids**
☐ **Other:** ____

Have you had an EKG within the last 6 months: ☐ Yes ☐ No

Pulmonary (Lung):

Have you ever been diagnosed with any of the following: ☐N/A

☐ **Asthma** ☐ **Sleep Apnea/Prescribed a CPAP/BPAP** ☐ **Pulmonary Embolism**

☐ **Emphysema** ☐ **Home Oxygen Use: How many liters_________ AM/PM**

☐ **COPD** ☐ **Tuberculosis – Year Diagnosed ___________**

☐ **Other Pulmonary issues?** ____

Renal (Kidney):

Have you ever been diagnosed with any of the following: ☐N/A

☐ **Kidney Failure** ☐ **Urinary Incontinence** ☐ **Prostate**

☐ **Other renal issues?** ____

Hepatic (Liver):

Have you ever been diagnosed with any of the following: ☐N/A

☐ **Cirrhosis** ☐ **Hepatitis** ☐ **Fatty Liver**

☐ **Other hepatic issues?** ____

Neurologic (Nervous System):

Have you ever been diagnosed with any of the following: ☐N/A

☐ **Seizure** ☐ **Vertigo** ☐ **Vaso-Vagal Episodes**

☐ **Dizzy Spells/Fainting** ☐ **Stroke (ministrokes or TIA's)** ☐ **Multiple Sclerosis**

☐ **Parkinson's Disease** ☐ **Alzheimer's Disease** ☐ **Cognitive Impairments**

☐ **Migraines that require treatment**

☐ **Numbness, Weakness or Tingling** ☐Yes ☐No **If yes, Location:** ☐ Right Leg ☐ Left Leg ☐Right Arm ☐Left Arm

☐ **Other Neurologic Conditions?** ____

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GI (Stomach and Intestine):

Have you ever been diagnosed with any of the following: ☐N/A

☐ **GERD/Acid Reflux/Heartburn** ☐ **Hiatal Hernia** ☐ **Loss of bowel control**

☐ **Stomach Ulcers** ☐ **Esophageal Varices** ☐ **Inflammatory Bowel Disease (IBD)**

☐ **Other GI Conditions?** ____

Endocrine (Glands):

Have you ever been diagnosed with any of the following: ☐N/A

☐ **Diabetes (including borderline and diet controlled)** ☐ **Type I** ☐ **Type II** ☐ **Prediabetic**

☐ **Thyroid Disease**

☐ **Other Endocrine Conditions?** ____

Oncologic (Cancer):

Have you ever been diagnosed with any of the following: ☐N/A

Cancer ☐ Yes ☐ No

If yes, Cancer diagnosis: ____

Are you currently receiving treatment? ☐ Yes ☐ No

Infectious Disease:

Have you ever been diagnosed with any of the following: ☐N/A

☐ **MRSA (Methicillin-Resistant Staphylococcus Aureus)**

☐ **VRE (Vancomycin-Resistant Enterococcus)**

☐ **Cdiff (Clostridioides Difficile)**

☐ **Other infectious diseases?** ____

Hematologic (Blood):

Have you ever been diagnosed with any of the following: ☐N/A

☐ **Anemia** ☐ **History of blood clots (PE or DVT)** ☐ **Blood Thinners**

☐ **Bleeding or clotting disorders** ☐ **Varicose veins or venous stasis** ☐ **HIV or AIDS**

☐ **Other hematologic conditions?** ____

Musculoskeletal (Muscle/Bones):

Have you ever been diagnosed with any of the following: ☐N/A

☐ **Musculoskeletal problems** ☐ **Arthritis** ☐ **Paralysis**

☐ **Myopathy (muscle weakness)**

☐ **Other musculoskeletal conditions?** ____

Psychiatric:

Have you ever been diagnosed with any of the following: ☐N/A

☐ **Depression** ☐ **Panic/Anxiety**

☐ **Other Psychiatric conditions?** ____

Do you have a history of claustrophobia, anxiety, depression, or PTSD? ☐ Yes ☐ No

If yes, please describe: ____

Gynecologic/Obstetrical:

Do any of the following apply: ☐N/A

☐ **Currently Pregnant** ☐ **Menopause.**

☐ **Do you currently have a menstrual period?** ☐ Yes ☐ No

Pain:

☐ **Do you have chronic pain?** ☐ Yes ☐ No

Anesthesia Complications:

Have you ever been diagnosed with any of the following: ☐N/A

☐ **Malignant Hyperthermia (Life threatening high temperature under anesthesia)**

☐ **Pseudocholinesterase deficiency (prolonged paralysis from muscle relaxants)**

☐ **Difficult intubation (difficulty placing breathing tube for general anesthesia)**

☐ **Motion Sickness**

☐ **Postoperative nausea and vomiting. Severity:** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

☐ **Other adverse reactions to anesthesia medication?** ____

List of surgeries you have had: ☐N/A

Past Surgery	Year

Do you have any allergies: Medication/Food/Other: ☐ Yes ☐ No (if yes, please list all allergies and reactions below)

Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:

Medication List

Please use this sheet to list all your medications. Please include vitamins, minerals, herbal supplements and any other over the counter (OTC) medicines that you take, even if they were not prescribed by your doctor.

☐ I do not currently take any medications, vitamins, or supplements.

List all medications the patient is currently taking including prescription, OTC, PRN, vitamins, topical and herbal products.

Medication/Vitamin/Supplement Name	How much do you take?	How often do you take this medication?	Reason for Medication