**PSCA** Physician Surgery Center of ALBUQUERQUE

# Preoperative Questionnaire

Dear Patient,
This questionnaire will help your anesthesia team determine what 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: ____________________

Patient Age: ________ Patient Height: _________ Patient Weight: ________

Phone #: ______________________________ Email: ________________________________

Surgeon: ______________________________ Date of Surgery: __________________________

Name of Person completing this form: ______________________________ Relation: ______________

**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: ________________________

**Specialist you are currently seeing or have seen in the last 5 years:**

Cardiologist Name: ________________________________________ Phone: ____________________

Pulmonologist Name: ______________________________________ Phone: ____________________

Other Name: _____________________________________________ Phone: ____________________

Other Name: _____________________________________________ Phone: ____________________

**Do/Did you ever use illegal drug(s) ?** ☐ Yes ☐ No

What drug(s): ______________

**Do/Did you ever use marijuana?** ☐ Yes ☐ No

How often: ______________

**Did you ever use IV drugs?** ☐ Yes ☐ No

If applicable, when did you quit? _________________

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

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**Can you climb a flight of stairs?** ☐ Yes ☐ No

**Please describe your physical activities.** (i.e. exercise often, run regularly, play tennis, able to mow lawn, poor exercise tolerance, get short of breath frequently, mostly sitting down throughout the day) ________________________________
________________________________________________________________________________
________________________________________________________________________________

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

| | | |
|---|---|---|
| ☐ **Kidney Disease** | ☐ **Asthma** | ☐ **Tuberculosis** |
| ☐ **Emphysema** | ☐ **GERD/Reflux/Heartburn** | ☐ **Hiatal Hernia** |
| ☐ **Cancer** | ☐ **Hepatitis** | ☐ **Cirrhosis** |
| ☐ **Seizure** | ☐ **Diabetes** | ☐ **Thyroid problem** |
| ☐ **HIV/AIDS** | ☐ **Sleep Apnea** | ☐ **Alzheimer's** |
| ☐ **Parkinsons** | ☐ **Demintia** | ☐ **Cognitive Impairments** |

**Have you or anyone related to you ever had a major complication that was related to receiving anesthesia?**
☐ Yes ☐ No
Do you have any anemia/clotting/blood or bleeding disorders ☐Yes ☐No

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

| | | |
|---|---|---|
| ☐ **Heart Murmurs** | ☐ **Pacemaker** | ☐ **Angina** |
| ☐ **Irregular Heartbeat** | ☐ **Ablation** | ☐ **Congestive Heart Failure** |
| ☐ **AFIB** | ☐ **Heart stents** | ☐ **AICD** |
| ☐ **Coronary Artery Disease** | ☐ **Vascular Disease** | ☐ **Heart Valve Issues** |
| ☐ **High Blood pressure** | ☐ **CABG/Bypass** | |
| ☐ **Heart Attack** | ☐ **Other:** ______________________________ | |

**Have you had an EKG within the last year:** ☐ Yes ☐ No

**Do you have diabetes?** ☐ Yes ☐ No
☐**Type I** ☐**Type II**
**Do you take any diabetes medication:** ☐ Yes ☐ No (if yes please list below in medications section)

**Do you have a history of claustrophobia, anxiety, depression, or PTSD?** ☐ Yes ☐ No
If yes, please describe: ____________________________________________

**Do you have a history of falls, problems with mobility or paralysis?** ☐ Yes ☐ No
If yes, please describe: ____________________________________________

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**List of surgeries you have had in the last 5 years:** ☐N/A

| Past Surgery | Year |
|---|---|
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**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: |

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# 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 |
|---|---|---|---|
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