

Preoperative Questionnaire

The Care Group, P.C.

830 Potomac Cir Suite 150

Aurora, CO 80011

303-343-3121 FAX: 303-343-3514

www.thecaregrouppc.com

Today's Date _____

The following questions are designed to help us get to know you better before your surgery.

Name _____ Age _____

Date of surgery _____ Type of surgery _____

Name of Surgeon _____

Where will surgery be performed? _____

FAX report to: _____

Type of anesthesia (e.g. general, spinal, local, etc.) _____

Is this surgery to be same day (outpatient)? YES NO Or in the hospital (inpatient)? YES NO

Please list all medical problems for which you have seen a physician in the last five years:

Please list previous surgeries you have had and their dates:

Did you have any significant surgical complications? YES NO

If YES, please describe: _____

Have you ever had a reaction or complication to anesthesia? YES NO

If YES, please describe: _____

To your knowledge, do you have a family history of surgical or anesthesia problems? YES NO

If YES, please describe: _____

Have you ever had a blood transfusion? YES NO

If YES, did you have a reaction to the transfusion (including fever)? YES NO

Have you donated your own blood ahead of time for this surgery? YES NO

Have you ever been told that you need antibiotics prior to a dental procedure or other surgery? YES NO

Do you have a prosthesis or artificial valve in your heart? YES NO

Are you currently pregnant or think you might be pregnant? YES NO

Do you currently have an upper respiratory infection? YES NO

Please list any drug or food allergies and type of reaction (e.g. penicillin - rash; lisinopril - cough; shellfish - can't breath):

Please list all current medications which you take regularly. Please include all over-the-counter and any herbal medications (e.g. Ginkgo Baloba, Vitamin E, etc.):

Are you currently taking any blood thinning medicine (e.g. Coumadin)? YES NO

If YES, please list: _____

Have you taken aspirin or ibuprofen in the last 7 days? YES NO

Have you been treated with prednisone, cortisone or other steroids in the last year? YES NO

If YES, please list reason and drug:

Are you a cigarette smoker? YES NO

If YES, how many packs per day: _____ How many years have you been smoking? _____

Do you drink alcoholic beverages? YES NO

If YES, please indicate the number of drinks you have per week: _____

Do you use recreational drugs (e.g. Marijuana)? YES NO

If YES, what kind of drugs and how often: _____

Check Yes or No if you have had any of the following:

Diagnosis	NO	YES	Description
Anemia	_____	_____	_____
Angina or frequent chest pain	_____	_____	_____
Abnormal heart rhythm	_____	_____	_____
Asthma	_____	_____	_____
Artificial joint (e.g. hip, knee)	_____	_____	_____
Bleeding disorder or abnormal bleeding	_____	_____	_____
Family history of bleeding disorder	_____	_____	_____
Blood clot in the leg	_____	_____	_____
Blood clot in the lung	_____	_____	_____
** Chest pain	_____	_____	_____
** Shortness of breath	_____	_____	_____
Coronary artery disease	_____	_____	_____
Cirrhosis	_____	_____	_____
Congestive heart failure	_____	_____	_____
COPD (Chronic Obstructive Pulmonary Disease)	_____	_____	_____
Chronic bronchitis	_____	_____	_____
Cancer of any type	_____	_____	_____
Disease of the heart valves	_____	_____	_____
Diabetes	_____	_____	_____
Emphysema	_____	_____	_____
High blood pressure	_____	_____	_____
HIV risk factors	_____	_____	_____
Interstitial lung disease	_____	_____	_____
Kidney problems	_____	_____	_____
Liver disease or jaundice	_____	_____	_____
Lung disease	_____	_____	_____
Malnutrition	_____	_____	_____
Myocardial infarction (heart attack)	_____	_____	_____
Macular degeneration	_____	_____	_____
Obesity	_____	_____	_____
Peptic ulcer disease	_____	_____	_____
Peripheral vascular disease (blood vessels)	_____	_____	_____
Stroke or TIA's	_____	_____	_____
Thyroid disease	_____	_____	_____
Tuberculosis	_____	_____	_____
Von Willebrands	_____	_____	_____

***** STOP HERE *****

******* PHYSICIAN SECTION *******

Pertinent findings on evaluation:

S: _____

CC/HPI: _____

Preoperative Checklist

- | | |
|---|---|
| <input type="checkbox"/> Chest X-ray | <input type="checkbox"/> Biochemistry profile |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Pregnancy test |
| <input type="checkbox"/> PT / PTT / INR | <input type="checkbox"/> Spirometry |
| <input type="checkbox"/> Urinalysis | |

Was patient advised to stop aspirin and NSAIDs seven days before surgery? YES NO

Was patient advised to stop all supplements and OTC medications before surgery? YES NO

Will patient require antibiotic prophylaxis for prosthetic joint/valve? YES NO

Will patient require antiulcer or antireflux medication? YES NO

Will patient require DVT prophylaxis? YES NO

In your opinion, is this patient cleared for surgery? YES NO
