



BIG CREEK SURGERY CENTER PRE-OPERATIVE QUESTIONNAIRE AND ASSESSMENT

DATE OF SURGERY _____

SURGEON _____

PROCEDURE _____

DEAR PATIENT:

ANESTHESIA TYPE _____

THE SURGERY CENTER STAFF WELCOMES THE OPPORTUNITY TO PARTICIPATE IN YOUR MEDICAL CARE. TO SAVE YOU TIME, WE WOULD LIKE YOU TO FILL OUT THIS QUESTIONNAIRE AS ACCURATELY AS POSSIBLE.

WE THANK YOU FOR YOUR HELP AND LOOK FORWARD TO CARING FOR YOU ON THE DAY OF YOUR SURGERY. WE ARE AVAILABLE IF YOU HAVE ANY QUESTIONS.

DATE	HAVE YOU HAD SURGERY AT BIG CREEK SURGERY CENTER BEFORE? _____ WHEN? _____				
NAME		NICKNAME		FAMILY DOCTOR	
ADDRESS			CITY		STATE ZIP
HEIGHT	WEIGHT	SEX M <input type="checkbox"/> F <input type="checkbox"/>		HOME PHONE	WORK PHONE
AGE	DATE OF BIRTH		SOCIAL SECURITY NUMBER		PRE OP CALL
EMERGENCY CONTACT			RELATIONSHIP TO PATIENT		
PHONE NUMBER (OTHER THAN PATIENT)			ADDRESS (OTHER THAN PATIENT)		
MAY LEAVE PRE/POST SURGERY INFORMATION WITH PERSON AT RESIDENCE OR ON VOICE MAIL? YES _____ NO _____ (SIGNATURE) _____					CUSTODY? MOTHER, FATHER, BOTH OTHER? _____

PLEASE EXPLAIN ANY "YES" ANSWERS IN SPACE PROVIDED AT THE END OF THE QUESTIONNAIRE.

	YES	NO	COMMENTS
1. HAVE YOU OR ANYONE IN YOUR FAMILY EVER HAD A PROBLEM WITH ANESTHESIA, OTHER THAN NAUSEA OR VOMITING?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. ARE YOU, OR COULD YOU BE PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. DO YOU WEAR CONTACT LENSES?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. DO YOU HAVE A DRIVER 18YRS OR OLDER?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. DO YOU WEAR ANY DENTURES, BRIDGES, BRACES OR OTHER DENTAL APPLIANCES (LOOSE, CRACKED TEETH, ECT.)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. DO YOU DRINK ALCOHOLIC BEVERAGES? (IF YES, HOW MUCH DO YOU CONSUME?).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. DO YOU CURRENTLY SMOKE OR HAVE YOU SMOKED IN THE PAST? (IF YES, HOW MUCH FOR HOW LONG) (EG, 2 PACKS PER DAY x 30 YEARS).....	<input type="checkbox"/>	<input type="checkbox"/>	CURRENT SMOKER__ PACKS PER DAY X __ YEARS QUIT __ YEARS AGO __ PACKS PER DAY X __ YEARS
8. DO YOU CURRENTLY USE RECREATIONAL (STREET) DRUGS? (IF YES, LIST DRUGS AND LAST DATE OF USE).	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. DO YOU HAVE ANY NUMBNESS OR WEAKNESS OF ANY BODY PART?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. DO YOU HAVE ANY SPECIFIC QUESTIONS REGARDING THE RISK OF ANESTHESIA?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. DO YOU HAVE AN ADVANCED DIRECTIVE	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. HAVE YOU RECEIVED YOUR PATIENT HANDBOOK?	<input type="checkbox"/>	<input type="checkbox"/>	_____

C-PAP YES NO

LATEX ALLERGY YES NO
MEDS ALLERGY YES NO

LIST ALL MEDICATIONS, HERBAL, VITAMINS

LIST BELOW WITH REACTIONS

REACTIONS

DO YOU TAKE ASPIRIN, ASPIRIN PRODUCTS, ANTI INFLAMMATORY OR BLOOD THINNING DRUGS ON A DAILY BASIS? YES NO

YOU TAKE DIABETES MEDICATION (ORAL OR INSULIN)?

MEDICAL HISTORY

PLEASE CIRCLE ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT YOU HAVE NOW OR HAVE HAD IN THE PAST.

HEART PROBLEMS

- ANGINA OR CHEST PAINS
- C.H.F
- ANEMIA
- HEART ATTACK
- HEART MURMUR
- HIGH BLOOD PRESSURE
- MITRAL VALVE PROLAPSE
- PACEMAKER/DEFIBRILLATOR
- RHEUMATIC FEVER
- THROMBOPHLEBITIS

LUNG PROBLEMS

- ASTHMA OR EMPHYSEMA
- CHRONIC COUGH / BRONCHITIS
- SHORTNESS OF BREATH
- SLEEP APNEA/C-PAP
- TUBERCULOSIS
- LIVER / GASTROINTESTINAL**
- HIATAL HERNIA
- HEPATITIS
- ULCER
- SICKLE CELL DISEASE

KIDNEY/ENDOCRINE

- DIABETES
- THYROID PROBLEMS
- NEUROLOGICAL PROBLEMS**
- SEIZURE
- STROKE
- DEPRESSION
- ARTHRITIS / LOW BACK PAIN
- ANY TRANSMITTABLE DISEASE
- ALCOHOL / DRUG ADDICTION
- HIV

PLEASE LIST ANY OTHER MEDICAL ILLNESSES OR CONDITIONS YOU HAVE:

SURGICAL HISTORY: (LIST ALL OPERATIONS YOU HAVE HAD AND YEAR PERFORMED):

TESTING YES / NO	EKG	BW			
- ANESTHESIA REVIEWED:			NURSE SIGNATURE	DATE	TIME

SURGERY CENTER USE ONLY

TYPE OF ANESTHESIA AND RISKS

DISCUSSED WITH PATIENT/FAMILY? YES NO

- LOCAL WITHOUT ANESTHESIA COVERAGE
- MONITORED ANESTHESIA CARE
- GENERAL ANESTHESIA
- REGIONAL BLOCK
 - AXILLARY SPINAL ANKLE
 - BIER INTERSCALENE FIELD
 - EPIDURAL FEMORAL DIGIT
 - MEDIAN POPLITEAL _____
 - RADIAL ULNAR

ANESTHESIOLOGIST ASSESSMENT:

PHYSICAL EXAMINATION:

- HEENT - UNREMARKABLE _____
- NECK - SUPPLE _____
- HEART - REGULAR RATE & RHYTHM _____
- LUNGS - CLEAR TO AUSCULTATION _____
- ABDOMEN - NONTENDER TO PALPITATION _____
- MUSCULOSKELETAL - (SEE SURGEON'S ASSESSMENT) _____

LABS ORDERED:

- HCB & HCT _____
- K+ _____
- EKG _____
- OTHER _____
- NONE

ANESTHESIOLOGISTS SIGNATURE

DATE _____


