UMMC Preoperative and Preanesthetic Patient 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 to schedule an appointment for a preoperative evaluation either in the PREP center (at the University of Maryland Medical Center) or we will contact you for a preoperative evaluation over the phone. If you have any questions, you can contact us at 410-328-5750. Thank you!

Name: ______________________________ Person Completing Form: ____________ Title: ________
Age: ____________ Height: ______________ Weight: ______________ Date of Birth: __________
Surgeon: ______________________________ Proposed Surgery: __________________________
Proposed date of surgery: ______________

1. Your contact information:
   Home phone: __________________________ Work phone: __________________________
   Cell phone or pager: __________________________ E-mail address: __________________________
   Best time to reach you: AM PM (circle)
   Best way to reach you: home work cell/pager e-mail (circle)

2. Do you have a primary care doctor?
   Yes No (circle)
   Name: ____________________________________________________________________
   Address and phone number: ________________________________________________________

3. Do/Did you ever smoke?
   Yes No (circle)
   How many packs per day? __________________________
   How many years? __________________________
   If applicable, when did you quit? __________________________

4. Do/Did you ever drink alcohol?
   Yes No (circle)
   How often? __________________________
   How much? __________________________
   If applicable, when did you quit? __________________________

5. Do/Did you ever use “street” drugs?
   Yes No (circle)
   What drug? (circle) Cocaine Heroin Other: ________
   Did you ever use IV drugs? Yes No (circle)
   If applicable, when did you quit? __________________________

Please use the last page of this questionnaire to list all your medications, including over-the-counter herbals and vitamins, as well as “as needed” medications.

Please fax forms to 410-328-8125 for review when completed.
6. Do you have any allergies to medications?  
   Yes  No  (circle)  
   Drug: ________________________ What happens? __________________________  
   Drug: ________________________ What happens? __________________________  
   Drug: ________________________ What happens? __________________________  
   Drug: ________________________ What happens? __________________________  

7. Do you have any allergies to substances other than medications?  
   Yes  No  (circle)  
   (Circle all that apply)  
   Betadine/Iodine  Latex  Eggs  Other: ______________  
   Gadolinium  IV contrast  Tape  

8. List all the surgeries you have had in the past (most recent first).  
   (Use back of page for additional information)  
   Year: ____________ Surgery: ______________________ Hospital: ____________________  
   Year: ____________ Surgery: ______________________ Hospital: ____________________  
   Year: ____________ Surgery: ______________________ Hospital: ____________________  
   Year: ____________ Surgery: ______________________ Hospital: ____________________  

9. Have you or anyone related to you ever had a major complication that was related to receiving anesthesia?  
   Yes  No  (circle)  

10. Have you had blood drawn for testing in the past three months?  
    Yes  No  (circle)  
    Date: ____________ Place: __________________________________________________________  

11. Have you had a chest x-ray in the past year?  
    Yes  No  (circle)  
    Date: ____________ Place: __________________________________________________________  

12. Have you ever had an EKG done?  
    Yes  No  (circle)  
    Date: ____________ Place: __________________________________________________________  
    Date: ____________ Place: __________________________________________________________  

13. Have you ever had any heart problems (for example, congestive heart failure, angina (chest pain), heart attack, arrhythmia)?  
    Yes  No  (circle)  
    Date: ____________ Problem: __________________________ Hospital: ____________________  
    Date: ____________ Problem: __________________________ Hospital: ____________________  
    Date: ____________ Problem: __________________________ Hospital: ____________________  

14. Do you have an Automatic Internal Cardiac Defibrillator (AICD) or pacemaker?  
    Yes  No  (circle)  
    If “Yes”, do you know the model and the name of the maker?  
    Model ____________ Company ______________________________  
    (Please bring your device pocket card with you to the hospital.)  

15. Have you ever had any special heart tests? (for example, stress tests, echocardiograms, cardiac catheterization)  
    Yes  No  (circle)  
    Date: ____________ Test: ______________________ Place: ______________________  
    Date: ____________ Test: ______________________ Place: ______________________  
    Date: ____________ Test: ______________________ Place: ______________________
16. Can you climb one flight of stairs without stopping? Yes No (circle)

17. 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) __________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

18. Have you ever had a lung function test (spirometry)? Yes No (circle)
Date: __________ Place: ______________________________

19. Have you ever been diagnosed with any of the following (circle all that apply):
- Peripheral vascular disease
- Bleeding or clotting problems
- Stroke or mini stroke
- Kidney disease
- Asthma
- Tuberculosis
- Emphysema
- GERD/Reflux/Heartburn
- Hiatal hernia
- Cancer
- Hepatitis
- Cirrhosis
- Seizure
- Diabetes
- Thyroid problems
- HIV/AIDS
- High Blood Pressure

20. Specialists you are currently seeing or have seen in the past five years:
(You do not need to list your surgeon for the proposed procedure here).
Cardiologist Name: __________________________ Phone: __________________
Pulmonologist Name: __________________________ Phone: __________________
Nephrologist Name: __________________________ Phone: __________________
Hematologist Name: __________________________ Phone: __________________
Oncologist Name: __________________________ Phone: __________________
Other Name: __________________________________ Specialty: ____________ Phone: __________________
Other Name: __________________________________ Specialty: ____________ Phone: __________________

21. Have you been diagnosed with obstructive sleep apnea? Yes No (circle)
Do you use CPAP/BiPAP? Yes No (circle)
Have you had a sleep study? Yes No (circle)
Date: __________ Place: ______________________________

22. Are there any specific things you would like your anesthesiologist to know?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Medication List

Please use this sheet to list out your medications. Please include vitamins, minerals, herbal supplements and other over the counter (OTC) medicines that you take even if they were not prescribed by your doctor. It is important to list everything you take even if you only take them once in a while or if only as needed. We need to know because it may affect you during and after surgery and some medicines (even herbal supplements) can interact with other medications you receive during your hospital stay. If you are not sure about your medication or pills, bring everything with you when you come in, so that the nurse or doctors can review them with you.

<table>
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<th>Name of medicine, vitamin or supplement</th>
<th>How much do you take? (Tablets and milligrams, if you know)</th>
<th>How often do you take this medicine? (once a day, or more or less often)</th>
<th>What is the reason you are you taking this medicine?</th>
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