Staple

3-Hole 5/16 4 1/4 c-to-c

UMMC Preoperative and Preanesthetic Patient Questionnaire

Date Completed: ________________________

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)

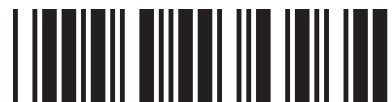
   How often? _____________________________________
   How much? _____________________________________
   If applicable, when did you quit? __________________

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.



Patient Name: ______________________________ Date of Birth: ________________

3-Hole 5/16 4 1/4 c-to-c

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: ____________________

Patient Name: ______________________________ Date of Birth: ________________

16. Can you climb one flight of stairs without stopping? Yes No (circle)

3-Hole 5/16 4 1/4 c-to-c

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	

5/1

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: ________________

5/1

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?

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Patient Name: ______________________________ Date of Birth: ________________

3-Hole 5/16 4 1/4 c-to-c

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.

Name of medicine, vitamin or supplement	How much do you take? (Tablets and milligrams, if you know)	How often do you take this medicine? (once a day, or more or less often)	What is the reason you are you taking this medicine?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
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17.			
18.			
19.			
20.			

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5/1