PARKWAY SURGERY CENTER

Preoperative Questionnaire

Name: _____Birth Date: _____Height: ___ft___in Weight: _____lbs.

In order to provide care that is safe and minimizes the potential for problems, please answer each question honestly and as accurately as possible. **If you do not know the answer to a question, leave it blank.**

Yes	No	
		1. Have **YOU** ever had any of the following problems with anesthesia? ☐ Fever ☐ Nausea/ Vomiting ☐ Slow to awaken ☐ Malignant Hyperthermia (MH) ☐ Pseudocholinesterase ☐Other:_____
		2. Have **BLOOD RELATIVES** ever had any of the following problems with anesthesia? ☐ Fever ☐ Nausea/ Vomiting ☐ Slow to awaken ☐ Malignant Hyperthermia (MH) ☐ Pseudocholinesterase ☐Other:_____
		3. Have you ever been diagnosed with Insulin Resistance? If yes, do you take medication? ☐ Yes ☐ No Medication:_____
		4. Do you have diabetes? If yes, do you check your blood sugar at home? ☐ Yes ☐ No ☐ Type I ☐ Type II If yes, what medication do you take:_____
		5. Do you have a thyroid condition? If yes, what:
		6. Have you ever had high blood pressure or hypertension? If yes, are you being treated at present for this? ☐ Yes ☐ No
		7. Have you ever had any diseases or disorders of your heart such as: ☐ Heart Attack: Date of attack. _____ When was your last visit to a Cardiologist._____ ☐ Chest Pain: How often? _____ ☐ Abnormal Heartbeat ☐ Pacemaker/Defibrillator ☐ Heart Artery Stents ☐ Angina ☐ Congestive Heart Disease or Failure ☐ Heart X-ray ☐ Valve Problems ☐ Palpitations or Racing Heart ☐ Bypass Surgery ☐ Other
		8. Have you ever had any diseases or disorders with your lungs or breathing problems such as: ☐ Pneumonia ☐ Bronchitis ☐ COPD ☐ Shortness of Breath ☐ Asthma ☐ Sleep Apnea ☐ TB or x-ray for TB ☐ Other
		9. Have you had a recent fever, cold, or flu?
		10. Have you ever had any diseases or disorders with your liver such as: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Liver Failure ☐ Cirrhosis ☐ Other
		11. Have you ever had any diseases or disorders of your kidneys such as: ☐ Kidney Stones ☐ Bladder or Kidney Infections ☐ Blood in the Urine ☐ Kidney Failure ☐ Dialysis ☐ Other
		12. Any diseases or disorders with your nervous system such as: ☐ Stroke: Date of stroke._____ ☐ Injuries from an accident(s). Describe_____ ☐ Seizure(s): How often_____ When was your last one_____ ☐ Myasthenia Gravis ☐ Brain Tumor(s) ☐ Depression/Anxiety ☐ Autism ☐ Multiple Sclerosis ☐ Fibromyalgia ☐ ADHD ☐ Other
		13. Have you ever had any diseases or disorders of your esophagus, stomach, or intestines such as: ☐ Hiatal Hernia ☐ GE Reflux ☐ Ulcers ☐ Swallowing Problems ☐ Other: Explain _____

Patient Sticker

Yes	No	
		14. Have you ever had any blood diseases or disorders such as: ☐ Anemia ☐ Leukemia ☐ Von Willebrand Disease ☐ Clotting Problems ☐ Bleeding Problems ☐ HIV/AIDS ☐ Other: Explain _____
		15. Have you ever had blood clots in your legs? ☐ Yes ☐ No Have you ever had blood clots in the lungs (pulmonary embolism)? ☐ Yes ☐ No If yes, do you take any of the following: ☐ ASA/Aspirin ☐ Lovanox ☐ Coumadin ☐ Eloquist ☐ Plavix **Time of last dose:**_____
		16. Any congenital problems present at birth that could affect health care, anesthesia care, or surgery?
		17. Have you ever had: ☐ MRSA If yes, last culture obtained:_____ Results: ☐ negative ☐ positive ☐ unknown ☐ VRE If yes, last culture obtained:_____ Results: ☐ negative ☐ positive ☐ unknown ☐ CDIFF If yes, last culture obtained:_____ Results: ☐ negative ☐ positive ☐ unknown Is the CDIFF currently active: ☐ Yes ☐ No
		18. Do you currently or have you ever used any of the following: ☐ Cigarettes. If yes, how long and how often:_____ ☐ Quit_____ years ago ☐ Tobacco. If yes, how long and how often:_____ ☐ Quit_____ years ago ☐ Alcohol. If yes, the last time alcohol was consumed & how much:_____ ☐ Quit_____ years ago
		19. Do you or have you ever used drugs? If yes, how often do you use:_____ Last time you used:_____ Purpose of use: ☐ Recreational ☐ Other: Explain_____
		20. Do you have any diseases or disorders of the muscles or skeletal system such as: ☐ Numbness, Weakness, or Paralysis of extremities ☐ Joint Replacement ☐ Rheumatoid Arthritis ☐ Osteoarthritis (joint problems) ☐ TMJ ☐ Other:_____
		21. Have you ever had any kind of cancer? If yes, please list the cancer type, where it was located, and when it was found. _____ Have you ever had Chemotherapy or Radiation treatments? ☐ Yes ☐ No
		22. Have you traveled outside of the U.S. in the last 3 weeks? If yes, where:_____
		23. Do you have any special health care needs we should be aware of such as: ☐ Anxiety ☐ Learning ☐ Language ☐ Religion ☐ Other: Explain _____
		24. Have you had an organ transplant? If yes, how long ago & what was it:_____
		25. Do you have any artificial devices, hardware, or implants in your body? If yes, please list the location(s)_____

Please list ALL previous surgeries and dates:

_____ _____ _____

_____ _____ _____

Please list the **pharmacy** you use _____City_____

The information provided above is correct and complete

Patient or Legal Guardian Signature_____Date_____

Reviewed by: RN_____Date_____

☐ **NO CHANGES**: Date_____

_____Patient Initial Patient Sticker

_____RN Initial