NewYork-Presbyterian
The University Hospital of Columbia and Cornell

50705

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

GENERAL PATIENT INFORMATION: (To be completed by Patient, Guardian or Admitting Nurses)

Name: ______________________________

Fluent in English: ☐ Yes ☐ No Language Spoken: ______________________ Translator needed: ☐ Yes ☐ No

Age: ____________ Sex: ____________ Date of Birth: ______/______/______

Surgeon Name: ______________________________ Expected Date of Surgery ____/____/____

Primary Care Physician: ______________________________

Primary Care Physician's Phone No. (______) ______________

Cardiologists Name ______________________________ Phone No.: (______) ______________

Expected Procedure: ______________________________

Home Phone: (______) ____________ Work Phone: (______) ____________ Cell Phone: (______) ____________

Telephone Number to be Reached Prior to Surgery: ______________________________

Best time to call: ☐ Afternoon ☐ Evening May we leave a message? ☐ Yes ☐ No

Do you have allergies? ☐ Yes ☐ No ☐ FOOD ☐ DRUG ☐ LATEX ☐ OTHER ______________

ALLERGEN	REACTION

LIST PRIOR SURGERY **DATE** **COMPLICATIONS** (IF ANY)

____

____

____

____

____

____

What previous Anesthesia have you had?

☐ General ☐ Regional ☐ Spinal ☐ Epidural ☐ Local ☐ None ☐ Unsure

Please list any complications/problems experienced with anesthesia.

____

____

____

Please list prior Hospitalizations including Emergency Room visits

____

____

____

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Heart

	PATIENT ONLY		CLINICIAN USE ONLY	
	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
1) Do you have a history of atrial fibrillation or irregular heartbeat?			EKG	*
2) Do you have a history of high blood pressure or mitral valve prolapse?			EKG	
3) Have you ever had a heart attack, heart disease, angina, or chest pain?			CBCP, EKG	*
4) Have you ever had rheumatic fever, a heart murmur or heart failure?			CBCP EKG	*
5) Do you have or have you been treated for high cholesterol?				
6) Have you ever had heart surgery?			EKG	*
7) Have you ever had a catherization of your heart? Date ___/___/___ Where ________				
8) Have you ever had a heart stress test? Date ___/___/___ Where ________				
9) Have you ever been told to take antibiotics prior to a surgical procedure or dental work?				
10) Are you 50 years old or older?			EKG	
11) Do you have a pacemaker or implantable defibrillator? (If yes, please bring your information card day of surgery)			EKG **If yes, contact EP specialist**	

Breathing

	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
12) Do you get shortness of breath on exertion or swollen ankles?			CBCP, EKG	*
13) Do you sleep on more than one pillow or wake up at night short of breath?			CBCP, EKG	
14) Have you ever had Tuberculosis (TB)?			CXR	
15) Have you smoked more than 1 pk/day for 20 yrs or 2 pks/day for 10 yrs?			CBCP, CXR	
16) Have you smoked in the last year?				
17) Do you use a machine at home to help you breath?			CBCP, CXR	*
18) Do you have severe emphysema, asthma or bronchitis (COPD) that limits your activities?			EKG, CXR	*
19) Did you ever have an embolus or clot go to your lung?				

Blood Disorders

	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
20) Do you have a history of anemia or low blood count?			CBCP	
21) Do you have a history of bleeding ulcers or rectal bleeding?			CBCP	
22) Do you have sickle cell disease or trait?			CBCP, CXR	
23) Do you use warfarin (Coumadin) as a blood thinner?			PT/INR	
24) Do you bruise easily and/or have a bleeding problem?			CBCP, PT/INR/APTT	*
25) Have you had phlebitis?				

* Anesthesia Consult Recommended
CBCP = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

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Endocrine Disorders

Question	PATIENT ONLY: No	PATIENT ONLY: Yes	CLINICIAN USE ONLY: Test for "Yes" Answers	CLINICIAN USE ONLY: Anesthesia Consult *
26) Do you have a history of diabetes?			BMP, EKG	
27) Do you have a history of adrenal and/or thyroid disease or tumor?			BMP	
28) Do you use diuretics (water pills), digoxin (Lanoxin) or steroids (Prednisone)?			BMP, EKG	
29) Do you have a history of kidney disease, kidney failure or are you on dialysis?			BMP, EKG, CBCP	*
30) Do you or have you ever had severe hepatitis, jaundice, cirrhosis or liver failure?			LIV, PT/INR/APTT	

Gastrointestinal/GU

Question	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
31) Do you suffer from abdominal pain?				
32) Have you ever had intestinal bleeding?				
33) Have you ever had diverticulitis or gall bladder trouble?				
34) Have you had burning pain or ulcer pain in your stomach?				
35) Have you noticed loss of appetite or unintentional weight loss in the past year?				
36) Do you get up at night to urinate?				
37) Do you have trouble starting your stream when you urinate?				

Neurological/Musculo/Skeletal

Question	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
38) Do you have a history of stroke or seizures?			BMP, EKG, CBCP	
39) Do you have weakness in your arms or legs?				
40) Have you ever blacked out or fainted?				
41) Have you ever had a brain aneurysm?				
42) Have you had head, neck or back injuries?				
43) Do you have chronic pain?				
44) Do you have arthritis?				
45) Do you suffer from "pins and needles" or loss of sensation in your arms or legs?				
46) Do you have a "collagen disease", Lupus, Rheumatoid arthritis, or Raynaud's disease?				

Obstetrics

Question	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
47) Are you or do you believe you might be pregnant?			BHCG	
Last menstrual cycle ______________.				
48) Have you been pregnant in the last 3 months?			If yes to (#47 & #48) a blood specimen must be sent < 72 hours of surgery for T & S and T & C	

Cancer

Question	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
49) Do you have a history of cancer and/or received chemotherapy?			CBCP	
50) Have you received radiation therapy?			CXR, EKG, CBCP	
51) Have you had an axillary lymph node dissection (under arm): ☐ Yes ☐ No Which side: ______________				

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	PATIENT ONLY		CLINICIAN USE ONLY	
Anesthesia Related Issues	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
52) Has anyone had problems placing a breathing tube in your windpipe (trachea) for surgery?........				*
53) Have you had surgery on your throat, vocal cords or lungs?........				*
54) Have you had an allergic or life-threatening reaction to anesthesia?........				*
55) Do you or any of your relatives have a history of Malignant Hyperthermia?........				*
56) Do you have trouble opening your mouth or bending your neck forward or backward?........				*
57) Are you having Bariatric (weight loss), Vascular or Thoracic Surgery (chest)?........				*
58) Do you want to see an Anesthesiologist before the day of Surgery?				*
Communicable Disease				
59) Do you have any of the diseases listed below? Please check all that apply: ☐ SARS ☐ HERPES ☐ AIDS ☐ HIV				
60) During the last month have you been in contact with anyone suspected of having SARS?........				
61) Have you traveled outside of the U.S. in the last month? If yes, where? ________				
Eyes				
62) Do you have dry eyes?........				
63) Have you ever had eye surgery?........				
64) Do you have glaucoma or cataracts?........				
Behavioral Health				
65) Have you suffered from anxiety, depression, or a psychiatric disorder?........				
Blood Transfusion				
66) Have you had a blood transfusion in the last 3 months?........			If yes to (#66) a blood specimen must be sent < 72 hours prior to surgery for T&S and T&C	
67) Have you had a reaction or allergy to a blood transfusion?........				
68) Did you donate blood for this surgery?........				
69) Did a family member donate blood?........				

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CBCP = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

Patient / Guardian Signature ________________________ Date: ____/____/______

If completed by the RN: ________________________ RN Date: ____/____/______
Nurses Signature

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PRE-OP TESTING DOCTOR'S ORDERS / ADULTS

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

AUTOMATIC STOP ORDER POLICY	RE-ORDER TIME	AUTOMATIC STOP ORDER POLICY	RE-ORDER TIME
Intravenous fluids (for fluid replacement) Other large volume parenterals / Irrigations All controlled substances (including epidural infusions and patient controlled analgesia)	7 days	All medications (including Intravenous and oral antibiotics) Warfarin	30 days 24 hours for the first 7 days, after that orders will be valid for 7 days if the patient is within therapeutic range

LEGIBILITY and COMPLETENESS of medication orders counts - Please follow these Guidelines:

- Write out "units"
- Use leading zero, eg. 0.1 mg
- Write out "days" or "doses"
- Write out "microgram"
- Omit trailing zero, eg. 1 mg
- Print medication order
- Print name and ID code
- Sign all orders
- Add beeper number

DATE/TIME	DOCTOR'S ORDERS AND DOCTOR'S SIGNATURE	ORDER POSTED BY WHOM DATE, TIME	ORDER CHECKED BY RN DATE, TIME	ORDER FAXED DATE, TIME
	*ALLERGIC/SENSITIVE TO:			
	Pre-op Testing Order(s)			
	☐ Lab / Test per Pre-op Medical Questionnaire (50705)			
	☐ Other Lab / Test			
	☐ Type & Cross per Maximum Surgical / Blood Order Schedule The link is: http://infonet.nyporg/Lab/Transfusio/Index.asp			
	☐ Type & Screen per Maximum Surgical / Blood Order Schedule The link is: http://infonet.nyporg/Lab/Transfusio/Index.asp			

(*) Required only for admissions, transfers where Graduate Staff coverage changes, and when new allergies are identified.