NewYork-Presbyterian
The University Hospital of Columbia and Cornell

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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Question	PATIENT ONLY: NO	PATIENT ONLY: YES	CLINICAL USE ONLY: Test for "Yes" Answers	CLINICAL USE ONLY: Anesthesia Consult *
Heart				
1) Do you have a history of a trial 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				
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				
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 trait?			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, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

PATIENT ONLY	CLINICAL USE ONLY

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Endocrine disorders				
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				
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				
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 you r arms or legs?				
46) Do you have a "collagen disease", Lupus, Rheumatoid arthritis, or Raynaud's disease?				
Obstetrics				
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				
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 axillary lymph node dissection? (under arm): Yes No Which side_____________				

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Anesthesia Related Issues				
52) Has anyone had problems placing a breathing tube in your windpipe (trachea) for surgery?				*
53) Have you had surgery on your throat, vocal chords 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 the U.S. in the last month? If yes, where? ______________________________				
Eyes				
62) Do you have any 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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Patient / Guardian Signature ___________________________________ Date: ____/ ____/ ______

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