CENTER FOR PREOPERATIVE ASSESSMENT AND PLANNING HEALTH QUESTIONNAIRE

Please check (✓) the appropriate boxes (☐) and fill in the blanks as needed.

NAME:			**DATE OF BIRTH:**
AGE:	**GENDER:** ☐ Male ☐ Female	**HEIGHT:**	**WEIGHT:**
PRIMARY PHONE #:		**SECONDARY PHONE #:**	
PRIMARY CARE PROVIDER – INCLUDE CITY:			**PHONE:**
CARDIOLOGIST (IF APPLICABLE) **– INCLUDE CITY:**			**PHONE:**
OTHER SPECIALIST(S) (LUNG, KIDNEY, DIABETES, CANCER, ETC):			

Allergies/sensitivities: ☐ No known allergies ☐ Latex ☐ IV contrast/dye

Other: _____

_____

Have you ever had any problems with anesthesia *or* surgery?

☐ Yes ☐ No

Have any of your relatives had problems with anesthesia *or* surgery?

☐ Yes ☐ No

Have you received a blood transfusion in the last 90 days?

☐ Yes ☐ No

Do you have any beliefs that would prevent you from accepting a blood transfusion if needed?

☐ Yes ☐ No

For Females only:

Are you currently pregnant or lactating?

☐ Yes ☐ No

Have you been pregnant in the last 90 days?

☐ Yes ☐ No

When was your last menstrual period? _____

Are you taking any blood thinning medications? (ex: Warfarin, Coumadin, Xarelto, Eliquis, Pradaxa, Lovenox, Plavix, Aspirin, etc.)

☐ Yes ☐ No

Have you ever been isolated for an infection where visitors wore gowns or masks?

☐ Yes ☐ No

Who will be the responsible adult caring for you for 24 hours after discharge?

_____

_____

Do you have any of the following?

☐ Yes ☐ No Visual impairments (blindness)

☐ Yes ☐ No Hearing impairments (deaf)

☐ Yes ☐ No Need for assistive devices: (ex: cane, walker, wheelchair)

CONTINUED ON BACK ➡

DO NOT WRITE BELOW THIS LINE

CENTER FOR PREOPERATIVE ASSESSMENT AND PLANNING HEALTH QUESTIONNAIRE

Have you had any of the following conditions in the past *or* currently?

☐ Yes ☐ No **High blood pressure / hypertension**

☐ Yes ☐ No **Coronary artery disease *or* heart disease**

☐ Yes ☐ No **Heart attack (MI)**

Date (if yes): _____

☐ Yes ☐ No **Heart stents**

☐ Yes ☐ No **Heart surgery**

☐ Yes ☐ No **Heart failure (CHF)**

☐ Yes ☐ No **Heart valve problem**

☐ Yes ☐ No **Heart murmur**

☐ Yes ☐ No **Irregular *or* abnormal heart rhythm**

☐ Yes ☐ No **Heart defibrillator *or* pacemaker**

☐ Yes ☐ No **Chest pain *or* chest discomfort**

☐ Yes ☐ No **Shortness of breath with activity**

☐ Yes ☐ No **Shortness of breath when lying down**

☐ Yes ☐ No **Stress test *or* cardiac cath**

Date: _____

☐ Yes ☐ No **Echocardiogram** Date: _____

List any past surgeries or procedures *or* attach list (please include the year completed if known):

_____

_____

_____

_____

_____

_____

_____

_____

Have you had any of the following conditions in the past *or* currently?

☐ Yes ☐ No **Stroke *or* TIA** - Date (if yes): _____

☐ Yes ☐ No **Vascular disease (artery or vein problems)**

☐ Yes ☐ No **Blood clots (DVT *or* PE)**

☐ Yes ☐ No **Diabetes** - Type (if yes): _____

☐ Yes ☐ No **Kidney disease *or* low kidney function**

☐ Yes ☐ No **Asthma**

☐ Yes ☐ No **COPD, emphysema *or* chronic bronchitis**

☐ Yes ☐ No **Home oxygen use**

☐ Yes ☐ No **Tracheostomy**

☐ Yes ☐ No **Sleep apnea (OSA)**

☐ Yes ☐ No **Liver problems, cirrhosis *or* hepatitis**

☐ Yes ☐ No **Anemia**

☐ Yes ☐ No **Blood transfusion**

☐ Yes ☐ No **Excessive bleeding *or* bleeding condition**

☐ Yes ☐ No **Acid reflux *or* heartburn**

☐ Yes ☐ No **Hiatal hernia**

☐ Yes ☐ No **Trouble swallowing**

☐ Yes ☐ No **Cancer** - Type (if yes): _____

☐ Yes ☐ No **Thyroid problems**

☐ Yes ☐ No **Lupus *or* other autoimmune condition**

☐ Yes ☐ No **Oral steroid use (pills)**

☐ Yes ☐ No **Seizures *or* epilepsy**

☐ Yes ☐ No **Neuromuscular disorder**

☐ Yes ☐ No **HIV**

☐ Yes ☐ No **Urinary infection *or* problems urinating**

Other medical conditions: _____

_____

Person completing form: _____
(PLEASE PRINT NAME AND RELATION)

Signature: _____ **Date:** _____

DO NOT WRITE BELOW THIS LINE