Penn Medicine
Princeton Medical Center

Name:
DOB:
Today's Date:

Anesthesia Pre-Operative Screening Questionnaire

Best Contact Phone Number(s):_____

Surgeon: _____

Type of surgery: _____ **Date of Surgery:**_____

Height: _____ **Weight**_____ **Age**_____

Primary Care Physician (Name and Phone #)_____

Cardiologist (Name and Phone #)_____

Please list any MEDICATION ALLERGIES or circle NONE **Latex Allergy? YES NO**

ALLERGY	REACTION

ALLERGY	REACTION

List current medications, including blood thinners, insulin, inhalers, pain pills, patches and supplements: (Please be specific)

MEDICATION	DOSE	FREQUENCY

MEDICATION	DOSE	FREQUENCY

List previous surgeries/procedures and any complications:

Year	Procedure	Complications

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TESTING: **EKG CHEST XRAY HEMOGLOBIN A1C**

If you have had an EKG or Hemoglobin A1c in the last 6 months or Chest XRay in the last year, please obtain a copy from your physician and bring to PAT, or have them fax it to 609-853-7361

SOCIAL HISTORY:

Do you now or have you ever smoked? Yes No Packs a day_____ Number of Years ____ Year you quit ____

Do you drink alcohol? Yes No Number of drinks per day _____

Do you have any history of substance abuse or dependence? Yes No

Type of Substance_____ Last Use _____

MEDICAL HISTORY: **Have you EVER had any of the following?** (Please circle YES or NO)

Heart and Vascular Problems:

YES NO High blood pressure or hypertension?
YES* NO Do you get chest pain or shortness of breath when you climb a flight of stairs or walk up a hill?*
YES* NO Coronary artery disease, chest pain, heart attack, angioplasty or cardiac stent? If yes, when _____
YES* NO **ABNORMAL** stress test, heart catheterization, echocardiogram or EKG?
YES* NO Congestive heart failure (fluid in the lungs)?
YES* NO Cardiac arrhythmia or irregular heart beat (atrial fibrillation, ventricular tachycardia)?
YES* NO Pacemaker or ICD (implantable cardiac defibrillator)?
YES* NO Severe disease of heart valves or valve replacement?
YES* NO Have you ever had surgery on your carotid artery, and/or aorta (peripheral vascular disease)?

Respiratory or Breathing Problems:

YES* NO "Wheezing," recent flare up of COPD (Emphysema, chronic bronchitis) or Asthma requiring medications?
YES* NO Have you ever had a tracheostomy?
YES* NO Do you use home Oxygen? If yes, how many liters _____
YES* NO Sleep apnea? If yes, do you use a CPAP: YES NO
YES NO Do you have any current cough or cold symptoms, recent upper respiratory infection or illness?

Neurological Problems:

YES* NO Dementia or Alzheimer's?
YES* NO Stroke (CVA) or mini-stroke (TIA)? If yes, when _____Residual effects_____

Endocrine or Metabolic Problems:

YES* NO Diabetes? Type I OR Type II

Gastrointestinal or Liver Problems:

YES* NO Cirrhosis of the liver, fatty liver, Hepatitis or abnormal liver enzymes?

Kidney Problems:

YES* NO Kidney failure requiring dialysis? If yes, what days of the week do you receive dialysis_____

Blood Problems:

YES NO Anemia (low red blood cells)? Have you ever needed a transfusion: Yes No
YES* NO Thrombocytopenia (low platelet count)?
YES* NO Blood clotting problems or excessive bleeding (Hemophilia, von Willebrand's disease)?

Anesthesia Problems:

YES* NO Do you have a personal or family history of malignant hyperthermia, porphyria, or prolonged paralysis?
YES* NO Have you been told it was difficult to place a breathing tube in your airway (intubation)?
YES* NO Have you had severe nausea/vomiting or other severe reaction after anesthesia?

Other:

YES NO Cancer? What kind? _____ Chemotherapy or radiation? When _____
YES NO History of anxiety, depression, bipolar, or schizophrenia?
YES NO Is there a possibility you may be pregnant? Date of last menstrual period_____
YES* NO Do you refuse blood or blood products for any personal or religious reasons?
YES NO Is there anything else about your medical history not mentioned above? If yes, please describe:

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____ Time: _____