STRONG MEMORIAL HOSPITAL

PROCEDURE QUESTIONNAIRE

SMH 973 MR

Page 1 of 4

☐ Ambulatory Surgery Unit
☐ Same Day Admission
☐ 23°
☐ Inpatient

Date of Procedure: _____ DOB: _____

Admission Dx: _____ Medical Record # _____

Patient scheduled for: _____

Attending MD: _____ Primary Care MD: _____

PATIENT

We want to make your stay at Strong Memorial Hospital as safe and as easy as possible. Please take a few minutes to answer the following questions. Complete as much of the following 2 1/2 pages of the form as you can. Stop at the bold line on page 3. Please do not write in shaded areas. If you have any difficulty filling out this form, a nurse from the Preadmission Evaluation Center at Strong will help you.

Instructions: Please fill in the blank lines and all boxes that apply:

Have you ever been hospitalized or treated at Strong Memorial Hospital? ☐ Yes ☐ No Year _____

Name of person completing form: _____ Date: _____ Relation to Patient: _____

A. I have the following allergies to Medications, Food or Latex: ☐ ***None***

ALLERGIC TO	REACTION(S)	ALLERGIC TO	REACTION(S)
Example: Phenergan	rash		

B. I take the following Medications: (prescriptions, over the counter, vitamins, herbs) ☐ ***I do not take any medications***

MEDICATION	DOSE	HOW OFTEN	MEDICATION	DOSE	HOW OFTEN
Example: Colace	100 mg	one in AM			

Smoking History

1) Have you smoked at least 100 cigarettes in your whole life? ☐Yes ☐No

If Yes: please answer questions 2 & 3

2) Have you smoked ANY cigarettes during the 3 months before your cycle began? ☐Yes ☐No

3) The number of cigarettes you've smoked on average during the 3 months before your cycle? _____

☐ Beta-blocker Protocol Implemented; Date: _____
Recommended Post-op Duration 1-2 Weeks

C. I have had the following Surgeries: ☐ ***I have never had surgery***

YEAR	SURGERY	ANESTHESIA	COMPLICATIONS	YEAR	SURGERY	ANESTHESIA	COMPLICATIONS
Example: 1947	Appendectomy	1. General 2. Spinal/Epid 3. Local/block	Nausea				

Rev. 4/05

D. ☐ **A family member had a reaction to anesthesia.** Relation: _____ Reaction: _____ ☐ **No Reaction**

	THIS COLUMN FOR STAFF USE ONLY
I have the following: ☐ None ☐ Loose teeth; broken teeth ☐ Glasses/contact lenses ☐ Caps or crowns ☐ Hearing aids ☐ Dentures/partials	
☐ **I do not speak and understand English.** ☐ **English speaking** I speak a language other than English: _____ ☐ I am hearing impaired.	
I have used ☐ **CIGARETTES** ☐ **PIPE** ☐ **CIGAR** ☐ **CHEW** ☐ **Never** ☐ I smoke ____ packs a day for ____ years. ☐ I quit smoking ____ years ago. I used to smoke ____ packs a day for ____ years.	
I have had the following RESPIRATORY illnesses: ☐ None ☐ Cold or other respiratory infection within last month ☐ Chronic obstructive pulmonary disease (emphysema or chronic bronchitis) ☐ Asthma ☐ I use home oxygen ☐ My breathing is not at its best ☐ My breathing limits my physical activities ☐ Sleep apnea ☐ Pneumonia: I was treated _____ ☐ Tuberculosis: I was treated _____ ☐ Other: _____	
I have had the following HEART illnesses: ☐ None ☐ High blood pressure for _____ years ☐ Arrhythmia, irregular heart beat, or palpitations ☐ These make me dizzy or lose consciousness ☐ Chest pain, heaviness, pressure, or tightness ☐ Angina ☐ Its duration or intensity have recently changed ☐ Heart attack(s) Date(s) _____ ☐ Congestive heart failure ☐ Coronary angioplasty or stent ☐ Heart valve disease or murmur ☐ Mitral valve prolapse ☐ Other heart valve disease ☐ Pacemaker ☐ High cholesterol ☐ Automatic implantable cardioverter defibrillator (AICD) ☐ I have seen a cardiologist or had cardiac testing: ☐ Other: _____	FH -
Physical ACTIVITIES: ☐ No limitations I have trouble breathing or get chest pain when I: ☐ Climb one flight of stairs ☐ Do heavy work around the house like scrubbing floors ☐ Other: _____ I regularly participate in physical exercise/activities:	
I have had these GASTROINTESTINAL problems: ☐ None ☐ Heart burn or acid reflux (GERD - Gastroesophageal Reflux Disease) ☐ Stomach or duodenal ulcers ☐ Bowel problems ☐ Hepatitis B or C ☐ Liver failure ☐ Other: _____	
I have had the following BLEEDING problems: ☐ None ☐ Frequent nosebleeds or large bruises ☐ Blood clots ☐ Von Willebrands Disease ☐ Anemia ☐ Hemophilia ☐ I have family members with bleeding disorders ☐ Other: _____	
I have had KIDNEY diseases: ☐ None ☐ Kidney failure or abnormal kidney function ☐ I use peritoneal dialysis ☐ I use hemodialysis on the following days: _____ ☐ Stones ☐ Other: _____	
I have had the following JOINT problems: ☐ None ☐ Arthritis: ☐ Osteo (degenerative) ☐ Rheumatoid Where? ☐ Other: _____	
I have had PSYCHIATRIC disorders such as: ☐ None ☐ Depression ☐ Anxiety ☐ Other: _____	

I have had these ENDOCRINE illnesses: ☐ None ☐ Thyroid ☐ Diabetes ☐ Insulin Pump ☐ Other: _____	*THIS COLUMN FOR STAFF USE ONLY* FH -
I have had these NERVE OR MUSCLE illnesses: ☐ None ☐ Transient ischemic attack (TIA) ☐ Stroke ☐ I have continued weakness or numbness: ☐ Migraines ☐ Multiple sclerosis ☐ Myasthenia gravis ☐ Muscular dystrophy ☐ Malignant hyperthermia ☐ Seizures ☐ Other: _____	FH -
I have used the following: ☐ None ☐ Alcohol: I drink (how many) _____ drinks per _____ ☐ Recreational/Street drugs: types - _____ I use these every ___ days/weeks/months. Date of last use: _____	
☐ There is a chance I may be pregnant. ☐ **Not pregnant** Date of last menstrual period: _____	
☐ I have the following conditions not listed above (e.g., cancer): ☐ None _____ _____ _____ _____ _____	

Vital Signs: BP _____ P _____ RR _____ T _____ °C ht _____ in. wt _____ kg Room Air O_2 sat _____

RN Assessment: Above information reviewed and assessed by: _____ **RN** **Date** _____

ANESTHESIA ASSESSMENT

PROBLEM LIST / SUMMARY:

PHYSICAL EXAM: BMI: _____

	Yes	No	
Mental:	☐	☐	Alert/Oriented
			Other:
Airway:	I II III IV		Class
	☐	☐	Neck Extends Well
	☐	☐	Thyro-Mental Distance Adequate
	☐	☐	Mouth Opening Adequate
			Dentition:
Lungs	☐	☐	Clear to Auscultation
			Other:
Heart	☐	☐	Regular Rate & Rhythm
	☐	☐	No Murmur
			Other:

Labs:

EKG:

Other:

PLAN PER ANESTHESIOLOGIST:

☐ Beta blocker protocol initiated/continued

PHYSICAL STATUS 1 2 3 4 5 6 E

Anesthetic options discussed:

Anesthetic risks discussed: ☐ Nausea, vomiting, sore throat, dental injury, airway problems, eye injury, allergic reaction, nerve injury, unexpected serious injury / death

Invasive monitoring discussed: ☐ Arterial line ☐ Central Venous Line ☐ Pulmonary Artery Catheter ☐ Transesophageal Echocardiogram

Medication instruction:

NPO Advised: ☐ Department of anesthesiology guidelines

NPO confirmed:

Resident, Certified Nurse Anesthetist, NP Date / Time / Attending Date / Time

STRONG MEMORIAL HOSPITAL

PROCEDURE QUESTIONNAIRE

SMH 973 MR

Medical Record # _____

PHYSICAL EXAM: ☐ MD ☐ NP ☐ See Chart

HPI:

HEENT:

☐ normal PERRL, red reflex present bilateral EOMI, Oropharynx non-infected. No adenopathy. No thyromegaly.

TM: _____ Carotid: _____

☐ abnormal

NECK: ☐ normal (full range of motion)

☐ supple ☐ abnormal

Airways class:

Lungs / Thorax / Breasts: ☐ normal: clear all fields anterior & posterior

☐ abnormal

☐ Male

Last rectal / prostate exam _____

Rectal: ☐ Defer to admission

☐ Defer to 1° MD

☐ Done - results

☐ Female

Last Pap / Rectal _____

Last Mammogram _____

Heart: ☐ normal: RRR S_1S_2 without MRG

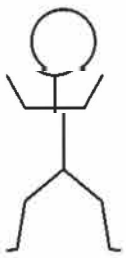
Abdomen: ☐ normal: soft, non-tender, 0 masses, 0 organomegaly, 0 bruits. Bowel sounds x 4 quadrants

☐ abnormal

Extremities: ☐ normal: pink, warm, 0 edema

☐ abnormal

	Fem	POP	PT	DP	Rad	Brac
R						
L						



Neurologic: ☐ normal: Alert & Oriented x 3, speech clear, sensation intact, gait sturdy

strength: _____ Cranial Nerves: _____

☐ abnormal

Assessment / Plan: ☐ NPO per policy ☐ Questions answered ☐ Preoperative teaching ☐ Transportation home

MD/Resident/NP Signature | Date/Time | Attending Surgeon | Date / Time

KEY: Fem - Femoral; POP - Popliteal; PT - Posterior Tibial; DP - Dorsalis Pedis; EOMI - Extra Ocular Motions Intact; MRG - Murmur Rub or Gallop; PERRL - Pupils Equal Round React to Light; Rad - Radial; Brac - Brachial; RRR - Regular, Rate Rhythm; TM - Tympanic Membrane; FH - Family History