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Everything about us is all about you.

Fit for Surgery Preoperative Assessment Form

THIS SECTION FOR OFFICE USE:

Surgeon:_____ **DOS**_____

Procedure/Surgery: _____

Diagnosis: _____

HPI: _____

Location, Quality: _____

Severity, Duration, Timing, Context: _____

Associated Signs/Sx's: _____

Modifying Factors: Position change: Ice/Heat: Meds: Sleep/Rest:

Pt Name: _____

D.O.B. _____

Contact Number(s):

_____

FOR PATIENT COMPLETION PRIOR TO APPOINTMENT:

Primary Care Physician: _____ Phone: _____

Specialist (heart/lung/kidney etc.): _____

Specialist Phone: _____

CURRENT MEDICATIONS: ***PLEASE USE ATTACHED FORM*** Bring all medications/supplements in original containers

PAST MEDICAL HISTORY: Allergies: _____

To the best of your ability, please fill in each that applies to your medical history ("I have *or* have had the following")

- ❍ High blood pressure
- ❍ High Cholesterol
- ❍ **Heart Attack**
  - **Date:** _____
- ❍ **Angina/Chest pain**
- ❍ **Heart Failure**
- ❍ **Heart valve disease**
- ❍ **Irregular heartbeat**
- ❍ Heart murmur
- ❍ Treadmill/Stress Test
  - ❍ Positive (date) _____
- ❍ Heart cath/angioplasty
- ❍ **Heart stent (bring card)**
- ❍ **Heart surgery**
  - **Date:** _____
- ❍ **Pacemaker/Defibrillator**
- ❍ Blood vessel disease
- ❍Congenital Heart disease
- ❍ Leg/extremity swelling

- ❍ **Shortness of breath**
  - ❍ **When lying flat**
- ❍ CPAP use
- ❍ **Wheezing**
- ❍ **Recent cough/cold**
- ❍ Asthma
- ❍ Emphysema/COPD
- ❍ Home oxygen use
- ❍ Pneumonia
- ❍ Tuberculosis
- ❍ Obstructive sleep apnea
- ❍ Loud snoring
- ❍ Tracheostomy
- ❍ **Steroid/prednisone use**
- ❍ **Hepatitis/jaundice**
- ❍ **Other liver disease**
- ❍ **Kidney disease**
- ❍ **Kidney Failure**
  - **Stage**: _____
  - **Last creatinine**: _____

- ❍ **Use dialysis (HD or PD)**
- ❍ **Stroke/TIA**
- ❍ **Blood thinner use**
- ❍ **Blood Clot (DVT or lung**
  - **Date:** _____
- ❍ **Bleeding disease**
- ❍ **Hemophilia**
- ❍ Sickle cell disease/trait
- ❍ **Anemia**
- ❍ Other neurologic disease
- ❍ Paralysis
- ❍ Dementia
- ❍ Alzheimer's disease
- ❍ Parkinson's disease
- ❍ Multiple Sclerosis
- ❍ Muscle disease
- ❍ Seizure
- ❍ Syncopal/Fainting spells

- ❍ **Diabetes**
  - ❍ **Insulin use**
    - **Last A1C** _____
- ❍ Thyroid disease
- ❍ Rheumatoid Arthritis
- ❍ Lupus (SLE)
- ❍ Cancer
  - ❍ with lymph node involvement
  - ❍ Metastases to other organs
- ❍ Chemotherapy
- ❍ Radiation therapy Date:_____
- ❍ **MRSA/VRE**
- ❍ Cdiff
- ❍ Reflux/GERD/frequent indigestion
- ❍ Other _____

PAST SURGICAL HISTORY/HOSPITALIZATIONS/RECENT ILLNESSES: _____

_____

FAMILY HEALTH HISTORY:

Family Member	Did They Have?	If Deceased – Age/Cause
Mother	❍ Diabetes ❍ Heart Disease ❍ Kidney disease ❍ Cancer	
Father	❍ Diabetes ❍ Heart Disease ❍ Kidney disease ❍ Cancer	
Brothers/Sisters	❍ Diabetes ❍ Heart Disease ❍ Kidney disease ❍ Cancer	

Please fill in the box which best describes your normal level of activity:

Do you exercise regularly? ❍ **No / ❍Yes** How many days per week?_____

- ❍ I am able to run, swim, play tennis, play basketball, ski, or perform similar activities **(≥10 METS**)
- ❍ I am able to perform yard work (ex: raking leaves, mowing the grass with a push mower), climb stairs, walk up a hill **(5-8 METS)**;
- ❍ I am able to perform light house work (ex: dusting, sweeping, some vacuuming), grocery shopping, walking **(≥4 METS)**;
- ❍ I am able to perform limited activities (ex: dressing, bathing, preparing meals, self-feeding) or **(≤ 1 MET)**.
- ❍ I need assistance with (Please circle) bathing, toileting, dressing, feeding, and/or I am wheelchair/bedbound.

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QUESTIONNAIRE: Please answer whether you have had any of the following:

- Prior difficulty with anesthesia or surgery? ❍ **No /** ❍ **Yes** - Had nausea/vomiting after surgery? ❍ **No /** ❍ **Yes**
- Do you or a family member have any history of Malignant Hyperthermia? ❍ **No /** ❍ **Yes** - Difficult Intubation? ❍ **No /** ❍ **Yes**
- History of blood transfusion? ❍ **No** / ❍ **Yes** Did you have a reaction ❍ **No** / ❍ **Yes** Reaction: _____
- Have you ever smoked cigarettes? ❍ **No /** ❍ **Yes** Do you currently smoke cigarettes? ❍ **No /** ❍ **Yes**
  If yes, how many packs of cigarettes per day do you smoke?_____How many years?_____yrs.
  Do you currently use any other form of tobacco? ❍ **No /** ❍ **Yes** Type: _____
- Do you use alcohol? ❍ **No /** ❍ **Yes** If yes, please circle type(s): Wine, beer, liquor
  Avg. # drinks/day_____Per Week? _____
- Do you use recreational drugs? ❍ **No /** ❍ **Yes** If yes, what type _____
  Date of recent/last use?_____
- Have you had a surgical history and physical by your surgeon's office? ❍ **No /** ❍**Yes**
- Have you signed consent/permission for your surgery/procedure? ❍ **No /** ❍**Yes**

Please check symptoms you have experienced within the past 30 days (Please fill in answers that apply):

General:	**NO**	**YES**
Good general health lately	❍	❍
Recent weight change	❍	❍
Weight loss in last 6 months	❍	❍
How much weight loss?_____(lbs.)		
Were you trying to lose weight?	❍	❍
Loss of appetite?	❍	❍
Head/Eyes:		
Vision difficulty/Use Glasses	❍	❍
Blindness	❍	❍
Reading difficulty	❍	❍
Head ache	❍	❍
Ears/Nose/Throat:		
Hearing difficulty	❍	❍
Sinus problems/Congestion	❍	❍
Nose or throat irritation	❍	❍
Ear Pain	❍	❍
Respiratory:		
Frequent cough	❍	❍
Coughing up blood	❍	❍
Shortness of breath	❍	❍
Sputum	❍	❍
Recent Inhaler use	❍	❍
Wheezing	❍	❍
Gastrointestinal:		
Abdominal pain or heartburn	❍	❍
Change in bowel patterns	❍	❍
Blood in stool	❍	❍
Black tarry stool	❍	❍
Nausea or vomiting	❍	❍
Diarrhea	❍	❍
Constipation	❍	❍
Trouble swallowing	❍	❍
Genitourinary:		
Frequent urination	❍	❍
Burning or painful urination	❍	❍
Blood in urine	❍	❍
Incontinence or dribbling	❍	❍
Trouble initiating stream	❍	❍
Weak urine stream	❍	❍
Gynecologic:		
Normal menstrual cycle	❍	❍
Female-hot flashes	❍	❍
Female breast pain or discharge	❍	❍

General:	**NO**	**YES**
Fever/chills/night sweats	❍	❍
Sleep problems	❍	❍
MRSA/VRE Exposure	❍	❍
Fatigue	❍	❍
Need mobility assistance	❍	❍
Circle one: cane, wheelchair, walker, artificial limb		
Musculoskeletal:		
Joint pain	❍	❍
Joint stiffness or swelling	❍	❍
Muscle pain	❍	❍
Back pain	❍	❍
Cardiovascular		
Chest pain	❍	❍
Palpitations	❍	❍
Swelling in legs or feet	❍	❍
Fainting	❍	❍
Neurologic:		
Frequent headaches	❍	❍
Seizure	❍	❍
Numbness/Tingling (Hands/Legs)	❍	❍
Lightheaded or dizzy	❍	❍
Forgetfulness	❍	❍
Change in mood/orientation	❍	❍
Psychiatric:		
Hallucinations	❍	❍
Depression/feeling sad	❍	❍
Loss of interest in activities	❍	❍
Anxiety/nervousness	❍	❍
Thoughts of suicide	❍	❍
Endocrine:		
Excessive thirst	❍	❍
Heat or cold intolerance	❍	❍
Excessive urination	❍	❍
Excessive hunger	❍	❍
Hematologic/Lymphatic:		
Easy bruising or bleeding	❍	❍
Enlarged glands or lumps	❍	❍
Recent blood transfusion	❍	❍
Anemia	❍	❍
Skin:	❍	❍
Hives/suspicious spots	❍	❍
Rash/itching	❍	❍

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MEDICATIONS: Please list ALL prescription medications, non-prescription medications, over the counter medications, herbal supplements, and vitamins you currently take.

Please bring ALL medications in original containers

Please include any additional information you feel would be beneficial.

_____

_____

_____

_____