NORTH CAROLINA BAPTIST HOSPITAL

Department of Anesthesiology
Winston-Salem, NC

PREOPERATIVE ASSESSMENT CLINIC

PREOPERATIVE ASSESSMENT

Surgeon's Name:_____

Procedure/Surgery: _____

Screening Nurse/LPN: _____/_____

FOR PATIENT COMPLETION PRIOR TO PAC APPOINTMENT

Patient: Please Complete (Name, Date of Birth)

Name: DOB:

Office Use: (Place Sticker Here)

CURRENT MEDICATIONS: (**Bring a list of all medications, vitamins, supplements, drops you are currently taking; including herbal supplements):**

_____

_____

_____

ALLERGIES: (medications, latex, nuts, eggs, shellfish/type of reaction): ❍ **Latex Allergy**

_____

Prior Surgeries / Hospitalizations / Serious Injuries (bring separate list if space inadequate, include dates)

_____

_____

_____

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 have any history with Malignant Hyperthermia?❍ No / ❍ Yes Difficult Intubation? ❍ No / ❍ Yes

Could you be pregnant? ❍ No / ❍ Yes Date of last menstrual period: ___/__/____

Risk factors for HIV/ Hepatitis? (I.V. drug use, sexual exposure)? ❍ No / ❍ Yes Recent blood transfusion? ❍ No / ❍ Yes

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

Have you ever tried to quit? ❍ No / ❍ Yes Date? ___/__/____How many yrs did you smoke before quitting?____

Have you smoked cigarettes within the past year? ❍No / ❍ Yes

Do you currently use smokeless tobacco? ❍ No / ❍ Yes Use Cigars? ❍ No / ❍ Yes

Do you use alcohol? ❍ No / ❍ Yes If yes, please circle type: Wine, beer, liquor Avg. # drinks per week?_____

Do you use street drugs? ❍ No / ❍ Yes If yes, circle type (Marijuana, cocaine, other) Date of recent/last use?_____

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 **(≥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 bathing, toileting, dressing, feeding, and/or I am bedbound. (Please circle)

Please fill in each that applies to your medical history (i.e. "I have or have had the following"):

❍ High blood pressure	❍ Shortness of breath	❍ Kidney Failure	❍ Blood thinner use
❍ Heart Attack	❍ When lying flat	❍ Use dialysis (HD or PD)	❍ Bleeding disease
❍ Angina/Chest pain	❍ Recent cough/cold	❍ Stroke/TIA	❍ Hemophilia
❍ Irregular heartbeat	❍ Asthma	❍ Seizure	❍ Sickle cell disease/trait
❍ Heart valve disease	❍ Emphysema/COPD	❍ Syncopal/Fainting spells	❍ Cancer
❍ Heart murmur	❍ Home oxygen use	❍ Other neurologic disease	❍ Cancer with lymph node involvement
❍ Treadmill/Stress Test	❍ Pneumonia	❍ Paralysis	❍ Metastases to other organs
❍ Positive (date) _____	❍ Tuberculosis	❍ Dementia	❍ Chemotherapy (Treatment date:___/___/___)
❍ Heart cath/angioplasty	❍ Obstructive sleep apnea	❍ Alzheimer's disease	❍ Radiation therapy (Treatment date:___/___/___)
❍ Heart stent (bring card)	❍ Loud snoring	❍ Parkinson's disease	❍ MRSA/VRE
❍ Heart surgery	❍ Bronchitis	❍ Diabetes	❍ Multiple Sclerosis
(Date) _____	❍ Tracheostomy	❍ Insulin use	❍ Muscle disease
❍ Pacemaker/Defibrillator	❍ Hepatitis/jaundice	❍ Thyroid disease	❍ Back problems
❍ Blood vessel disease	❍ Other liver disease	❍ Rheumatoid Arthritis	❍ Anemia
❍ Leg/extremity swelling	❍ Steroid/prednisone use	❍ Lupus (SLE)	❍ Reflux/GERD/frequent indigestion
❍Congenital Heart disease	❍ Kidney disease	❍ Down 's syndrome	❍ Other _____

TO BE COMPLETED BY PATIENT:

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 loose weight?	❍	❍
Loss of appetite?	❍	❍
Alcohol Use? (Beer, Wine, Liquor?)	❍	❍
Do you consume > 2 drinks/ day?	❍	❍
How many drinks/day in the past week?_____		
Eyes:		
Vision difficulty/Use Glasses	❍	❍
Blindness	❍	❍
Reading difficulty	❍	❍
Ears/Nose/Throat:		
Hearing difficulty	❍	❍
Sinus problems	❍	❍
Nose or throat concerns	❍	❍
Respiratory:		
Frequent cough	❍	❍
Coughing up blood	❍	❍
Shortness of breath	❍	❍
Climbing one flight of stairs?	❍	❍
Recent Inhaler use	❍	❍
Wheezing	❍	❍
Gastrointestinal:		
Abdominal pain or heartburn	❍	❍
Change in bowel patterns	❍	❍
Blood in stool	❍	❍
Black tarry stool	❍	❍
Nausea or vomiting	❍	❍
Frequent diarrhea	❍	❍
Constipation	❍	❍
Trouble swallowing	❍	❍
Genitourinary:		
Frequent urination	❍	❍
Burning or painful urination	❍	❍
Blood in urine	❍	❍
Incontinence or dribbling	❍	❍
Trouble initiating stream	❍	❍
Weak urine stream	❍	❍
Gynecologic:		
Nml 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	❍	❍
Skin:		
Rash	❍	❍
Itching	❍	❍
suspicious lesions or spots	❍	❍
Hair loss	❍	❍
Neurologic:		
Frequent headaches	❍	❍
Localized muscle weakness	❍	❍
Numbness/Tingling (Hands/Legs)	❍	❍
Lightheaded or dizzy	❍	❍
Forgetful	❍	❍
Psychiatric:		
Depression	❍	❍
Frequently sad or blue	❍	❍
Loss of interest in activities	❍	❍
Anxiety/nervousness	❍	❍
Endocrine:		
Excessive thirst or urination	❍	❍
Heat or cold intolerance	❍	❍
Occasional high blood pressure	❍	❍
Hematologic/Lymphatic:		
Easy bruising or bleeding	❍	❍
Enlarged glands or lumps	❍	❍
Recent blood transfusion	❍	❍
Allergic/Immunologic:		
Hay fever	❍	❍
Hives		
Food allergies	❍	❍
Immunodeficiency	❍	❍

Please answer the following: Marital Status: _____Other? _____
# of children /grandchildren:_____ Occupation: _____ Retired? _____
Note Level of Education completed: _____(# years)_____
Primary Physician's Name (City, State): _____ **Date of last visit**: _____/_____/_____
Doctor's Telephone/Fax Numbers: _____/_____ Did your doctor obtain blood tests at your last visit? **YES/NO**

❍ **No /** ❍**Yes** Have you had a surgical history and physical by your surgeon's office?

❍ **No /** ❍**Yes** Have you signed consent/permission for your surgery/procedure?