Preoperative Questionnaire

750 Potomac Street, Suite 111
Aurora, CO 80011
(303) 343-3121 Fax: (888) 268-3486
www.thecaregrouppc.com

Today's Date _____

The following questions are designed to help us get to know you better before your surgery.

Name _____ **Age** _____

Date of surgery: ____/____/____ Type of surgery: _____

Name of Surgeon: _____

Where will the surgery be performed? _____

FAX report to: _____

Type of anesthesia (e.g. general, spinal, local, etc.)_____

Is this surgery to be same day (outpatient)? ◯YES ◯NO Or in the hospital (inpatient)? ◯YES ◯ NO

Please list all medical problems for which you have seen a physician in the last five years:

_____
_____
_____
_____

Please list previous surgeries you have had and their dates:

_____
_____
_____
_____

Did you have any significant surgical complications? ◯YES ◯NO

If YES, please explain complication, type of surgery and dates:

_____

Have you ever had a reaction or complication to anesthesia? ◯YES ◯NO

If YES, please explain reaction, type of surgery and dates:

_____

_____

To your knowledge, do you have a family history of surgical or anesthesia problems? ◯ YES ◯ NO Explain below:

_____
_____

Have you ever had a blood transfusion? ◯ Yes ◯ No

If YES, did you have a reaction to the transfusion (including fever)? ◯ Yes ◯ No

Have you donated your own blood ahead of time for this surgery? ◯ Yes ◯ No

Have you ever been told that you need antibiotics prior to a dental procedure or other surgery? ◯ Yes ◯ No

Do you have a prosthesis or artificial valve in your heart? ◯ Yes ◯ No
Are you currently pregnant or think you might be pregnant? ◯ Yes ◯ No
Do you currently have an upper respiratory infection? ◯ Yes ◯ No

Please list any drug or food allergies and type of reaction, e.g., penicillin - rash; lisinopril - cough; shellfish - can't breathe:

Please list all current medications which you take regularly. Please include over-the-counter and any herbal medications (e.g. Ginko Baloba, Vitamin E, etc):

Are you currently taking any blood thinning medicine (e.g. Coumadin)? ◯ Yes ◯ No
If yes, please list:

Have you taken aspirin or ibuprofen in the last 7 days? ◯ Yes ◯ No

Have you been treated with prednisone, cortisone or other steroids in the last year? ◯ Yes ◯ No
If yes, please list reason and drug.

Are you cigarette smoker? ◯ Yes ◯ No

If yes, how many packs per day? _____ How many years have you been smoking? _____

Do you drink alcoholic beverages? ◯ Yes ◯ No
If YES, please indicate the number of drinks you have per week: _____

Do you use recreational drugs (e.g. Marijuana)? ◯ Yes ◯ No If yes, please describe below:

Check Yes or No if you have had any of the following:

Diagnosis	Yes	No	Description
Anemia			
Angina or frequent chest pain			
Abnormal heart rhythm			
Asthma			
Artificial joint			
Bleeding disorder or abnormal bleeding			
Family history of bleeding disorder			
Blood clot in leg			
Blood clot in lung			
Chest pain			
Shortness of breath			
Coronary artery disease			
Cirrhosis			
Congestive heart failure			
COPD (Chronic Obstructive Pulmonary Disease)			
Chronic bronchitis			
Cancer of any type			
Disease of the heart valves			
Diabetes			
Emphysema			
High blood pressure			
HIV risk factors			
Interstitial lung disease			
Kidney problems			
Liver disease or jaundice			
Lung disease			
Malnutrition			
Myocardial infarction (heart attack)			
Macular degeneration			
Obesity			
Peptic ulcer disease			
Peripheral vascular disease (blood vessels)			
Stroke or TIA's			
Thyroid disease			
Tuberculosis			
Von Willebrands			

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