

\_\_\_\_\_  
DOCTOR'S NAME

\_\_\_\_\_  
SURGERY DATE

**EVALUATION:**

1. If you are over 45, an electrocardiogram and certain laboratory tests may be required. Have these been scheduled?  
 YES       NO      EKG done at \_\_\_\_\_ LABS drawn at \_\_\_\_\_

2. Height \_\_\_\_\_ Weight \_\_\_\_\_

3. Is your physical activity ever limited due to **shortness of breath** or **chest pain**?     yes       no      Specify \_\_\_\_\_

4. Do you use Oxygen or a C-PAP machine at home?       yes       no      \_\_\_\_\_

5. Have you or any member of your family ever had a **bleeding** disorder?       yes       no      \_\_\_\_\_

6. Have you or any family member ever had a history of problems with anesthesia?     yes       no      \_\_\_\_\_

7. Any **allergies** to medications or any unusual drug reactions?       yes       no

Please list \_\_\_\_\_

8. **Do you smoke** or **Did you smoke**?     yes     no    Packs/Day? \_\_\_\_\_ How many years? \_\_\_\_\_ Stopped \_\_\_\_\_

9. Do you drink alcohol every day?     yes       no    If so, how much? \_\_\_\_\_

10. Do you take any medications regularly?       yes       no

MEDICATIONS	DOSE	FREQUENCY

MEDICATIONS	DOSE	FREQUENCY

INHALERS (bring them)

11. What pharmacy do you use? \_\_\_\_\_

12. Have you taken any aspirin, ibuprofen or **coumadin** in the last two weeks?     yes     no

If so, how much? \_\_\_\_\_ Does your surgeon know?     yes     no

Have you now or have you ever had?	YES	NO		YES	NO
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Implantable devices/pacemaker/defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in the legs	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer – list type _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C, or MRSA Bacterial Infection	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease/Heart attacks/Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/dizziness/blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Facial fractures	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Recent cold/infection (circle one)	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal hernia/heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Dentures/crowns/caps (circle one)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Loose/broken/chipped teeth/jaw pain (circle one)	<input type="checkbox"/>	<input type="checkbox"/>

Have you been hospitalized in the last year?     yes       no    If yes, why? \_\_\_\_\_

Do you have any significant illness or injury? \_\_\_\_\_

Do you have an Advance Directive/Health Care Power of Attorney?     yes       no

**Females:** Could you be pregnant?     yes       no    Date of last period \_\_\_\_\_ Hysterectomy?     yes       no  
 Anesthesia in the 1<sup>st</sup> trimester can cause miscarriage. Test can be run if you are unsure. Please inform your admitting nurse.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_