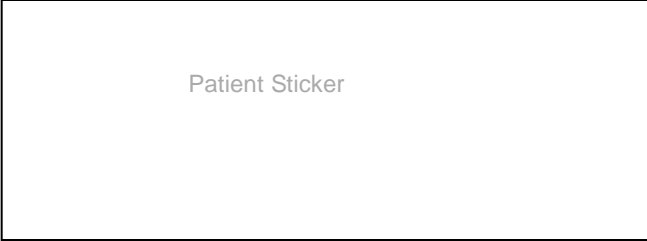


**Pre-Operative Patient Questionnaire For PASU**



Patient Name: \_\_\_\_\_  
 Patient Preferred telephone: \_\_\_\_\_  
 Type of Surgery: \_\_\_\_\_

Today's Date: \_\_\_\_\_  
 Date of Surgery: \_\_\_\_\_  
 Surgeon: \_\_\_\_\_

This questionnaire is the first step in collecting the baseline information to ensure that you are prepared and have the best outcomes during and after surgery.

**Primary Care Physician:** \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Date of last Visit: \_\_\_\_\_

**Local Pharmacy:** \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Medical History**

**Cardiovascular:**

- None
  - Coronary Artery Disease
  - Heart Valve Problems
  - Pacemaker/ICD
  - Coronary Bypass Surgery
  - Cardiologist:** [ ] Yes [ ] No
- Heart Valve Surgery
  - Heart Attacks/Stents
  - Heart Failure (CHF)
  - Cardiomyopathy
  - High Blood Pressure
- Atrial Fibrillation (Afib)
  - Other: \_\_\_\_\_
- If Yes, Name of Physician: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Date Last seen: \_\_\_\_\_
- Date of last stress test: \_\_\_\_\_ Where was it performed? \_\_\_\_\_  
 Date of other cardiac testing: \_\_\_\_\_ What was performed and at what location was it performed? \_\_\_\_\_
- Currently on Blood Thinner (Coumadin, Xarelto, Eliquis, Lovenox, Aspirin, etc.): [ ] Yes [ ] No  
 If yes, please list: \_\_\_\_\_

**Pulmonary:**

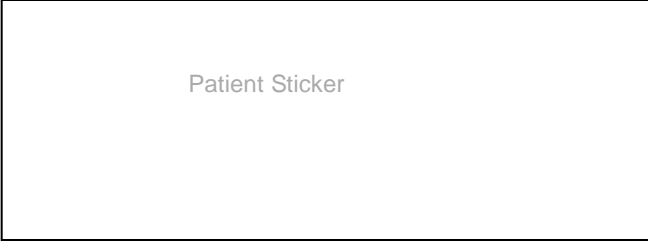
- None
  - COPD/Emphysema
  - Other: \_\_\_\_\_
- Asthma
  - Sleep Apnea
- CPAP or BiPap
  - Home O2
- Pulmonologist:** [ ] Yes [ ] No If Yes, Name of Physician: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Date Last seen: \_\_\_\_\_

**Hematologic:**

- None
  - DVT
  - Currently on Blood Thinner (Coumadin, Xarelto, Eliquis, Lovenox, Aspirin, etc.): [ ] Yes [ ] No
  - Hematologist:** [ ] Yes [ ] No
- PE
  - Clotting Disorder
- Abnormal Blood Counts
  - Other: \_\_\_\_\_
- If yes, please list: \_\_\_\_\_  
 If Yes, Name of Physician: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Date Last seen: \_\_\_\_\_

**Rheumatology:**

- None
  - Rheumatoid Arthritis
  - Currently taking any intravenous or injection medications; such as Enbrel, Remicade, Rituxan?
- Lupus
  - Use of Biologics/steroids
- Other: \_\_\_\_\_
- [ ] Yes [ ] No If yes, please list: \_\_\_\_\_  
 Date of last injection: \_\_\_\_\_



Neurological:

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> None                | <input type="checkbox"/> History of Post-Op Confusion                        | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stroke              |  | _____                                 |
| <input type="checkbox"/> Seizure             | <input type="checkbox"/> Falling or losing your balance in the last 3 months |                                       |
| <input type="checkbox"/> Parkinson's Disease |  |                                       |
| <input type="checkbox"/> Dementia/Alzheimer  |  |                                       |

Endocrine:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> None                | <input type="checkbox"/> Insulin Pump       | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Steroid Dependence | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Borderline Diabetes | <input type="checkbox"/> Hyperthyroidism    | _____                                   |

Renal:

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> None                                | <input type="checkbox"/> Dialysis          | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chronic Kidney Disease              | <input type="checkbox"/> Kidney Transplant | _____                                 |
| <input type="checkbox"/> <b>Nephrologist:</b> [ ] Yes [ ] No | If Yes, Name of Physician: _____           |                                       |
|  | Telephone: _____                           | Date Last seen: _____                 |

Gastrointestinal:

- |                                    |  |                                       |
|------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> None      | <input type="checkbox"/> GI Bleeding   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Liver Disease | _____                                 |

Infectious Disease:

- |  |                                       |                                       |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> History of Joint/Spine infection  | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> History of Osteomyelitis  | <input type="checkbox"/> Hep B/Hep C  | _____                                 |
| <input type="checkbox"/> Are you currently being treated for an active infection? [ ] Yes [ ] No |                                       |                                       |
| If yes, please list: _____   |                                       |                                       |

Vision and Dental:

- Do you have any current dental issues? [ ] Yes [ ] No  
 If yes, please list: \_\_\_\_\_
- Do you have any current vision issues/eye complications? [ ] Yes [ ] No  
 If yes, please list: \_\_\_\_\_

Skin Integrity:

- Do you have any current skin issues? [ ] Yes [ ] No  
 If yes, please list: \_\_\_\_\_

- Do you consume alcoholic beverages? [ ] Yes [ ] No Amount per week: \_\_\_\_\_
- Have you ever been treated for/experienced alcohol withdrawal? [ ] Yes [ ] No
- Tobacco Use? [ ] Yes [ ] No Vape Use? [ ] Yes [ ] No
- Are you currently taking Methadone or Suboxone/Buprenorphine? [ ] Yes [ ] No
- Is there any additional medical information that New England Baptist Hospital should know which may affect your surgery?  
 Are there any additional Specialist that you see?

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