Beth Israel Lahey Health
New England Baptist Hospital

Pre-Operative Patient Questionnaire For PASU

Patient Sticker

Patient Name: _____ Today's Date: _____
Patient Preferred telephone: _____ Date of Surgery: _____
Type 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
- ☐ Heart Valve Surgery
- ☐ Heart Attacks/Stents
- ☐ Heart Failure (CHF)
- ☐ Cardiomyopathy
- ☐ High Blood Pressure
- ☐ Atrial Fibrillation (Afib)
- ☐ Other: _____
- ☐ **Cardiologist:** [ ] Yes [ ] No 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
- ☐ PE
- ☐ Clotting Disorder
- ☐ Abnormal Blood Counts
- ☐ Other: _____
- ☐ Currently on Blood Thinner (Coumadin, Xarelto, Eliquis, Lovenox, Aspirin, etc.): [ ] Yes [ ] No
  If yes, please list: _____
- ☐ **Hematologist:** [ ] Yes [ ] No If Yes, Name of Physician: _____
  Telephone: _____ Date Last seen: _____

Rheumatology:

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

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Neurological:

- ☐ None
- ☐ Stroke
- ☐ Seizure
- ☐ Parkinson's Disease
- ☐ Dementia/Alzheimer
- ☐ History of Post-Op Confusion
- ☐ Falling or losing your balance in the last 3 months
- ☐ Other: _____

Endocrine:

- ☐ None
- ☐ Diabetes
- ☐ Borderline Diabetes
- ☐ Insulin Pump
- ☐ Steroid Dependence
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other: _____

Renal:

- ☐ None
- ☐ Chronic Kidney Disease
- ☐ **Nephrologist:** [ ] Yes [ ] No
- ☐ Dialysis
- ☐ Kidney Transplant
- ☐ Other: _____

If Yes, Name of Physician: _____
Telephone: _____ Date Last seen: _____

Gastrointestinal:

- ☐ None
- ☐ Cirrhosis
- ☐ GI Bleeding
- ☐ Liver Disease
- ☐ Other: _____

Infectious Disease:

- ☐ History of Joint/Spine infection
- ☐ History of Osteomyelitis
- ☐ HIV positive
- ☐ Hep B/Hep C
- ☐ Other: _____
- ☐ 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?

_____

_____