Preoperative Patient Questionnaire
Sinai Hospital of Baltimore

Please answer the questions and take this form with you when you have your history and physical completed. Bring this with you to the hospital on the day of surgery.

This questionnaire helps us identify risk factors that may affect your surgery, anesthesia or recovery.

1. Name ______________________ Height __________ Weight __________
2. Date of Birth ______________ Age __________ Sex ❑ Male ❑ Female
3. Surgeon's Name ______________________ Surgery Date __________
4. Name of Operation ______________________
5. Allergies ______________________

______________________ ❑ No Known Drug Allergies

6. Heart Assessment

If you answer YES to any of these questions, please make sure that your primary care physician reviews the list of tests required by the Department of Anesthesia. We will also need a copy of any EKG's, stress tests, etc.

	Question		Yes	No
A.	Do you have high blood pressure?		❑ Yes	❑ No
B.	Do you have irregular heartbeats or palpitations?		❑ Yes	❑ No
C.	Do you get chest pain or angina?		❑ Yes	❑ No
D.	Have you had a heart attack in the past 6 months?		❑ Yes	❑ No
E.	Have you ever had a heart attack?		❑ Yes	❑ No
F.	Do you get short of breath?		❑ Yes	❑ No
G.	Can you sleep flat in bed?		❑ Yes	❑ No
H.	Do you sleep on two or more pillows?		❑ Yes	❑ No
I.	Do you wake up at night short of breath?		❑ Yes	❑ No
J.	Have you ever had heart failure or congestive heart failure?		❑ Yes	❑ No
K.	Do you have a pacemaker?		❑ Yes	❑ No
L.	Do you have a prolapsed mitral valve?		❑ Yes	❑ No
M.	Have you had rheumatic fever or rheumatic heart disease?		❑ Yes	❑ No
N.	Do you have a heart murmur?		❑ Yes	❑ No
O.	Do you have a problem with a heart valve?		❑ Yes	❑ No
P.	Do you get muscle cramps when walking?		❑ Yes	❑ No
Q.	Have you been told that you have peripheral vascular disease?		❑ Yes	❑ No
R.	Have you had a TIA or transient ischemic attack (mini-stroke)?		❑ Yes	❑ No
S.	Have you had a stroke?		❑ Yes	❑ No
T.	Have you had heart surgery? When? ______________		❑ Yes	❑ No
U.	Have you had a cardiac catheterization? When? ______________		❑ Yes	❑ No
V.	Have you had a stress test? When? ______________		❑ Yes	❑ No
W.	Have you had an abnormal electrocardiogram?	❑ Not Sure	❑ Yes	❑ No

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7. Can you:

A. Take care of yourself (eat, dress, use the toilet)?	❑ Yes	❑ No
B. Walk around inside your house?	❑ Yes	❑ No
C. Walk a block on level ground at a leisurely pace?	❑ Yes	❑ No
D. Do light housework, dusting and dishes?	❑ Yes	❑ No
E. Climb a flight of stairs?	❑ Yes	❑ No
F. Walk on level ground at a fast pace?	❑ Yes	❑ No
G. Run a short distance?	❑ Yes	❑ No
H. Do heavy housework, scrub floors, lift heavy objects?	❑ Yes	❑ No
I. Participate in sports like bowling, dancing, golf, tennis?	❑ Yes	❑ No
J. Participate in strenuous sports like basketball, swimming or tennis?	❑ Yes	❑ No

8. Please list your current medications. **(Bring All Your Medications With You)**

Medication Name	Dose	How often you take it
1.		
2.		
3.		
4.		
5.		
6.		
7.		

9. Please list any surgeries you have had in the past.

Date	Surgery	Hospital Name	Complications
1.			
2.			
3.			
4.			
5.			
6.			

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10. Additional Information

If you answer YES to any of these questions, please make sure that your primary care physician reviews the list of tests required by the Department of Anesthesia.

A. Do you have diabetes?	❑ Yes	❑ No
B. Do you have a thyroid problem?	❑ Yes	❑ No
C. Do you have a bleeding tendency?	❑ Yes	❑ No
D. Do you have kidney problems?	❑ Yes	❑ No
E. Do you have sleep apnea?	❑ Yes	❑ No
F. Do you smoke?	❑ Yes	❑ No
G. Have you ever had a blood clot or pulmonary embolism?	❑ Yes	❑ No
H. Have you ever had problems with anesthesia?	❑ Yes	❑ No

11. Any Concerns: ______________________________

____

____

12. Preoperative Testing Information

My preoperative physical exam with my Primary Care Physician or Pediatrician is/was scheduled with:

PCP ______________________________ on date ______________

Telephone ______________ Fax (if known) ______________

Additional tests ______________________ are being done on ______________

My preoperative examination with my Surgeon is scheduled for ______________________

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