

Patient Label

**PREOPERATIVE ANESTHESIA
SCREENING**

Name: _____ DOB: ____/____/____ Age: _____ Gender: M F Wt: _____ lb. Ht: _____ in.
 Primary MD: _____ Last Visit: _____ Surgeon: _____
 Previous Surgery at UCIMC? Y N Best time to call: _____ Best number to reach you: (_____) _____
 Best time for Pre Op Visit: _____ Pre Op Phone interview: _____
 Will you be arriving from out of the area? Y N If yes, from where? _____

Patient Questionnaire

Please answer the following YES or NO questions to the best of your ability. If you are unsure, or have comments, please note the question in the comments at the end of each section.

CARDIOVASCULAR	YES	NO	Year	Hem./Onc./Infectious cont.	YES	NO	Year	NEUROPSYCHIATRY	YES	NO	Year
1. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	27. Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	50.* Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.* Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	28. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	51. Seizure	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.* Angina/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Type? _____				52. Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Heart Bypass surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	Comments: _____				53. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
5.* Pacemaker or Defibrillator*	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____				54. Headache	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>*If "YES," initiate pacemaker protocol</i>								55. Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Congestive Heart Failure/ Fluid in lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	GASTROINTESTINAL	YES	NO	Year	56. Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Palpitations/Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	_____	29. Alcoholic liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	57. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	30. Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	_____	58. Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Do you exercise? How often? _____ Type? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	31. Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____	Comments: _____			
10.* Have you ever seen a Cardiologist? Who? _____ Where? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	32. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Comments: _____				33. Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____	*FOR PEDIATRIC PATIENTS ONLY*			
				34. Alcohol use? Amount: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	1. Was child born prematurely? If YES, how many weeks premature were they? _____	<input type="checkbox"/>	<input type="checkbox"/>	
				35. Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	2. Problems noted at birth? If YES, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	
				Comments: _____							
				URINARY/REPRODUCTIVE	YES	NO	Year	PRIOR SURGERIES			
				36. Urinary/Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	1. _____ Date _____			
RESPIRATORY	YES	NO	Year	37.* Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Complications: _____			
11. Abnormal Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	_____	38.* Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>	_____	2. _____ Date _____			
12. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	39.* Peritoneal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Complications: _____			
13. Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	40. If Female, could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____	3. _____ Date _____			
14. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	41. Date of last menstrual period: _____				Complications: _____			
15.* Recent Respiratory Infection (within last 4 weeks)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Comments: _____				4. _____ Date _____			
16.* Shortness of Breath with Exertion/Activity	<input type="checkbox"/>	<input type="checkbox"/>	_____					Complications: _____			
17.* Can you lay flat on your back?	<input type="checkbox"/>	<input type="checkbox"/>	_____	ENDOCRINE	YES	NO	Year	5. _____ Date _____			
18. Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	_____	42. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Complications: _____			
19. Current Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	43. Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	6. _____ Date _____			
20.* Cough with Sputum Production	<input type="checkbox"/>	<input type="checkbox"/>	_____	44. Taken Steroids in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	_____	Complications: _____			
21. Do you smoke? How many years? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	Comments: _____				7. _____ Date _____			
Comments: _____								Complications: _____			
				MUSCULOSKELETAL	YES	NO	Year	8. _____ Date _____			
HEMATOLOGIC/ONCOLOGIC/ INFECTIOUS	YES	NO	Year	45. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Complications: _____			
22. Bleeding tendency (gums, nose)	<input type="checkbox"/>	<input type="checkbox"/>	_____	46. Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>	_____	7. _____ Date _____			
23. Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	_____	47. Neck, Back, Arm, Leg Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____	Complications: _____			
24. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	48. Herniated disc	<input type="checkbox"/>	<input type="checkbox"/>	_____	8. _____ Date _____			
25. Sickle Cell disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	49. Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	_____	Complications: _____			
26. Blood clots in legs or lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Comments: _____							

Please complete BOTH pages

Patient Label

UNIVERSITY of CALIFORNIA • IRVINE
HEALTHCARE

PREOPERATIVE ANESTHESIA
SCREENING

FAMILY HISTORY

1. Do you have any personal history of anesthetic complications? **YES NO**
If YES, please explain: _____
2. Is there a family history of anesthetic complications? **YES NO**
If YES, please explain: _____

BLOOD

1. Do you have any reason why you would refuse blood or blood products? **YES NO**
If YES, please explain: _____
2. Do you have an Advance Directive? **YES NO**
If YES, please bring on date of surgery.

MEDICATIONS (include over-the-counter and herbal)			Dose	Frequency	ALLERGIES (list all)		Reaction
1.					1.		
2.					2.		
3.					3.		
4.					4.		
5.					5.		
6.					6.		
7.					7.		
8.					8.		
9.					9.		
10.					10.		
11.					11.		
12.					12.		
13.					13.		
14.					14.		
15.					15.		
16.					16.		
17.					17.		
18.					18.		
19.					19.		
20.					20.		

Do you have any **comments or concerns** you would like to share with our staff? **YES NO**

PATIENT or GUARDIAN (PRINT NAME):

SIGNATURE:

DATE:

X

OFFICE USE ONLY

QUESTIONNAIRE REVIEWED BY: NAME/TITLE:

DATE:

Please complete BOTH pages