

# UMMC Preoperative and Preanesthetic Patient Questionnaire

Date Completed: \_\_\_\_\_

Dear Patient,

This questionnaire will help your anesthesia team determine what if any preoperative work up will be needed prior to your surgery and help them gather all available medical information about you. Please fill it out as best you can. This information will help to avoid any delay in your surgery.

In some cases, we will contact you to schedule an appointment for a preoperative evaluation either in the PREP center (at the University of Maryland Medical Center) or we will contact you for a preoperative evaluation over the phone. If you have any questions, you can contact us at **410-328-5750**. Thank you!

Name: \_\_\_\_\_ Person Completing Form: \_\_\_\_\_ Title: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Surgeon: \_\_\_\_\_ Proposed Surgery: \_\_\_\_\_

Proposed date of surgery: \_\_\_\_\_

### 1. Your contact information:

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone or pager: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Best time to reach you: \_\_\_\_\_ AM \_\_\_\_\_ PM (circle)

Best way to reach you: \_\_\_\_\_ home \_\_\_\_\_ work \_\_\_\_\_ cell/pager \_\_\_\_\_ e-mail (circle)

### 2. Do you have a primary care doctor? Yes No (circle)

Name: \_\_\_\_\_

Address and phone number: \_\_\_\_\_

### 3. Do/Did you ever smoke? Yes No (circle)

How many packs per day? \_\_\_\_\_

How many years? \_\_\_\_\_

If applicable, when did you quit? \_\_\_\_\_

### 4. Do/Did you ever drink alcohol? Yes No (circle)

How often? \_\_\_\_\_

How much? \_\_\_\_\_

If applicable, when did you quit? \_\_\_\_\_

### 5. Do/Did you ever use "street" drugs? Yes No (circle)

What drug? (circle) Cocaine Heroin Other: \_\_\_\_\_

Did you ever use IV drugs? Yes No (circle)

If applicable, when did you quit? \_\_\_\_\_

**Please use the last page of this questionnaire to list all your medications, including over-the-counter herbals and vitamins, as well as "as needed" medications.**

Please fax forms to 410-328-8125 for review when completed.



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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

6. Do you have any allergies to medications? Yes No (circle)

Drug: \_\_\_\_\_ What happens? \_\_\_\_\_  
Drug: \_\_\_\_\_ What happens? \_\_\_\_\_  
Drug: \_\_\_\_\_ What happens? \_\_\_\_\_  
Drug: \_\_\_\_\_ What happens? \_\_\_\_\_

7. Do you have any allergies to substances other than medications? Yes No (circle)  
(Circle all that apply)

Betadine/Iodine Latex Eggs Other: \_\_\_\_\_  
Gadolinium IV contrast Tape

8. List all the surgeries you have had in the past (most recent first).  
(Use back of page for additional information)

Year: \_\_\_\_\_ Surgery: \_\_\_\_\_ Hospital: \_\_\_\_\_  
Year: \_\_\_\_\_ Surgery: \_\_\_\_\_ Hospital: \_\_\_\_\_  
Year: \_\_\_\_\_ Surgery: \_\_\_\_\_ Hospital: \_\_\_\_\_  
Year: \_\_\_\_\_ Surgery: \_\_\_\_\_ Hospital: \_\_\_\_\_

9. Have you or anyone related to you ever had a major complication that was related to receiving anesthesia? Yes No (circle)

10. Have you had blood drawn for testing in the past three months? Yes No (circle)

Date: \_\_\_\_\_ Place: \_\_\_\_\_

11. Have you had a chest x-ray in the past year? Yes No (circle)

Date: \_\_\_\_\_ Place: \_\_\_\_\_

12. Have you ever had an EKG done? Yes No (circle)

Date: \_\_\_\_\_ Place: \_\_\_\_\_  
Date: \_\_\_\_\_ Place: \_\_\_\_\_

13. Have you ever had any heart problems (for example, congestive heart failure, angina (chest pain), heart attack, arrhythmia)? Yes No (circle)

Date: \_\_\_\_\_ Problem: \_\_\_\_\_ Hospital: \_\_\_\_\_  
Date: \_\_\_\_\_ Problem: \_\_\_\_\_ Hospital: \_\_\_\_\_  
Date: \_\_\_\_\_ Problem: \_\_\_\_\_ Hospital: \_\_\_\_\_

14. Do you have an Automatic Internal Cardiac Defibrillator (AICD) or pacemaker? Yes No (circle)

If "Yes", do you know the model and the name of the maker?

Model \_\_\_\_\_ Company \_\_\_\_\_  
(Please bring your device pocket card with you to the hospital.)

15. Have you ever had any special heart tests? (for example, stress tests, echocardiograms, cardiac catheterization) Yes No (circle)

Date: \_\_\_\_\_ Test: \_\_\_\_\_ Place: \_\_\_\_\_  
Date: \_\_\_\_\_ Test: \_\_\_\_\_ Place: \_\_\_\_\_  
Date: \_\_\_\_\_ Test: \_\_\_\_\_ Place: \_\_\_\_\_

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

16. Can you climb one flight of stairs without stopping? Yes No (circle)

17. Please describe your physical activities. (i.e. exercise often, run regularly, play tennis, able to mow lawn, poor exercise tolerance, get short of breath frequently, mostly sitting down throughout the day) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Have you ever had a lung function test (spirometry)? Yes No (circle)

Date: \_\_\_\_\_ Place: \_\_\_\_\_

19. Have you ever been diagnosed with any of the following (circle all that apply):

Peripheral vascular disease	Bleeding or clotting problems	Stroke or mini stroke
Kidney disease	Asthma	Tuberculosis
Emphysema	GERD/Reflux/Heartburn	Hiatal hernia
Cancer	Hepatitis	Cirrhosis
Seizure	Diabetes	Thyroid problems
HIV/AIDS	High Blood Pressure	

20. Specialists you are currently seeing or have seen in the past five years:  
(You do not need to list your surgeon for the proposed procedure here).

Cardiologist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Pulmonologist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Nephrologist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Hematologist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Oncologist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

21. Have you been diagnosed with obstructive sleep apnea? Yes No (circle)

Do you use CPAP/BiPAP? Yes No (circle)

Have you had a sleep study? Yes No (circle)

Date: \_\_\_\_\_ Place: \_\_\_\_\_

22. Are there any specific things you would like your anesthesiologist to know?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Medication List

**Please use this sheet to list out your medications. Please include vitamins, minerals, herbal supplements and other over the counter (OTC) medicines that you take even if they were not prescribed by your doctor. It is important to list everything you take even if you only take them once in a while or if only as needed. We need to know because it may affect you during and after surgery and some medicines (even herbal supplements) can interact with other medications you receive during your hospital stay. If you are not sure about your medication or pills, bring everything with you when you come in, so that the nurse or doctors can review them with you.**

Name of medicine, vitamin or supplement	How much do you take? (Tablets and milligrams, if you know)	How often do you take this medicine? (once a day, or more or less often)	What is the reason you are you taking this medicine?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			