Patient Label

UC Irvine Health

PREOPERATIVE ANESTHESIA SCREENING

DOB: _____/_____/_____ Age: _____ Gender: ☐ M ☐ F **Wt:** _____ lb. **Ht:** _____ in.
Email Address: _____
Primary MD: _____ Last Visit: _____ Surgeon: _____
Previous Surgery at UC Irvine Health? ☐ 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
High Blood Pressure	☐	☐	_____
***Heart Attack**	☐	☐	_____
***Angina/chest pain**	☐	☐	_____
Heart Bypass surgery	☐	☐	_____
CABG	☐	☐	_____
***Stents**	☐	☐	_____
Pacemaker or Defibrillator	☐	☐	_____
***If "YES," obtain pacemaker interrogation**			
Congestive Heart Failure/ Fluid in lungs	☐	☐	_____
Palpitations/Irregular heartbeat	☐	☐	_____
Heart murmur	☐	☐	_____
Do you exercise	☐	☐	
How often? _____			
Type? _____			
Comments: _____			

PULMONARY	YES	NO	Year
Abnormal Chest X-ray	☐	☐	_____
Asthma	☐	☐	_____
Bronchitis	☐	☐	_____
Emphysema	☐	☐	_____
***Recent Respiratory Infection** (within last 4 weeks)	☐	☐	_____
***Shortness of Breath with Exertion/Activity**	☐	☐	_____
***Can you lay flat on your back**	☐	☐	_____
Sleep Apnea	☐	☐	_____
☐ Snoring			
☐ Tired			
☐ Observed Stop Breathing			
☐ CPAP use at home			
Current Cough	☐	☐	_____
***Cough with mucous production**	☐	☐	_____
Have you ever smoked	☐	☐	_____
How many years _____			
Pulmonary Embolism	☐	☐	_____
Oxygen/Ventilator Use	☐	☐	_____
Comments: _____			

HEMATOLOGIC/ONCOLOGIC/ INFECTIOUS	YES	NO	Year
Anemia	☐	☐	_____
Sickle Cell disease	☐	☐	_____
Blood clots in legs or lungs	☐	☐	_____
HIV	☐	☐	_____
History of Cancer	☐	☐	_____
If Yes, Type of Cancer _____			
Location _____			
Chemotherapy	☐	☐	_____
When _____			
Type _____			
Radiation therapy	☐	☐	_____

GASTROINTESTINAL	YES	NO	Year
Alcoholic liver disease	☐	☐	_____
Acid Reflux	☐	☐	_____
Heartburn	☐	☐	_____
Hepatitis	☐	☐	_____
Jaundice	☐	☐	_____
Alcohol use	☐	☐	_____
Amount: _____			
Recreational drugs	☐	☐	_____

URINARY/REPRODUCTIVE	YES	NO	Year
Urinary/Kidney disease	☐	☐	_____
***Dialysis**	☐	☐	_____
***Hemodialysis**	☐	☐	_____
***Peritoneal Dialysis**	☐	☐	_____
If Female, could you be pregnant	☐	☐	_____
Date of last menstrual period: _____			

NEUROMUSCULAR DISEASE	YES	NO	Year
ALS	☐	☐	_____
Muscular Dystropy	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Parkinsons	☐	☐	_____
Guillain - Barre	☐	☐	_____
Other_____	☐	☐	_____

ENDOCRINE	YES	NO	Year
Diabetes	☐	☐	_____
Thyroid Disease	☐	☐	_____
Taken Steroids in the past year	☐	☐	_____
Comments: _____			

MUSCULOSKELETAL	YES	NO	Year
Arthritis	☐	☐	_____
Rheumatoid	☐	☐	_____
Neck, Back Arm, Leg Problems?	☐	☐	_____
Herniated disc	☐	☐	_____
Comments: _____			

NEUROPSYCHIATRY	YES	NO	Year
***Stroke**	☐	☐	_____
Seizure	☐	☐	_____
Fainting	☐	☐	_____
Dizziness	☐	☐	_____
Headache	☐	☐	_____
Depression	☐	☐	_____
Anxiety	☐	☐	_____
Psychiatric Care	☐	☐	_____
Comments: _____			

FOR PEDIATRIC PATIENTS ONLY

	YES	NO
Was child born prematurely	☐	☐
If YES, how many weeks premature were they _____		
Problems noted at birth	☐	☐
If YES, please explain: _____		

PRIOR SURGERY

Surgery: _____ Date
Complications:

Surgery: _____ Date
Complications:

Surgery: _____ Date
Complications:

88377

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

Please complete BOTH pages

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PREOPERATIVE ANESTHESIA SCREENING

Please provide the following information so we may contact your other physicians if necessary:

Primary MD Name: _____ Phone No: _____ Address: _____

Cardiologist Name: _____ Phone No: _____ Address: _____

Other Provider Name: _____ Phone No: _____ Address: _____

Patient Questionnaire

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 explain: _____		

Bleeding Questionnaire (Yes/No marked on order) **(POSITIVE = ONE YES)**

YES	NO	
		Have you had abnormal bleeding following: Dental extractions? Major/minor operations? Major/minor injuries?
		Do you have trouble with any of the following: Easy bruising (bigger than 2 inches)? Frequent nose bleeds? Abnormal heavy menstrual periods? Bleeding into joints or muscles? Oozing a long time from cuts or scrapes?
		Have you ever needed a blood transfusion for unexpected or heavy bleeding after a surgical procedure?
		Is there any family history of abnormal bleeding?
		Do you currently take any sort of anticoagulant (blood thinner) medication? (Coumadin, Lovenox, Pradaxa, etc.)

MEDICATIONS (include over-the-counter and herbal)	**Dose**	**Frequency**
☐ I do not take medication		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
Office Staff: Medications Updated in Quest on:		

Allergies (list all)	**Reaction**
☐ I do not take medication	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

Do you have any **comments or concerns** you would like to share with our staff? **YES** **NO**
You may receive a phone call from the Anesthesia Department based on your medical history.

_____

_____

_____

PATIENT or GUARDIAN (PRINT NAME): *SIGNATURE* *DATE*

X

OFFICE USE ONLY

QUESTIONNAIRE REVIEWED BY: NAME/TITLE: *DATE:*

Please complete BOTH pages