MedStar Washington Hospital Center

PRE-OPERATIVE PATIENT QUESTIONNAIRE

Patient's Name: *(Please Print)*			**Date of Surgery:**
Phone #	**Cell or work #**	**Surgeon Name:**	
Date of Birth:	**Height:** ☐ inch / ☐ cm	**Weight:**	☐ lbs / ☐ Kg
Primary Language:	**Do you need an interpreter?** ☐ yes	☐ no	

Please fill out this questionnaire carefully and hand it back to your surgeon's office receptionist, so that we have all the medical information to prepare you for your surgery. If you complete this questionnaire at home, fax form to 1-866-298-5563.
Failure to fill out this form correctly may delay your surgery.

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

If YES please check box and list date:

☐ Stress test–*date:*_____
☐ Heart echo (ultrasound) test–*date:*_____
☐ Nuclear medicine heart scan (MIBI) test–*date:*_____
☐ Holter rhythm test–*date:*_____
☐ Heart catheterization (angiogram)–*date:*_____
☐ Lung function test–*date:*_____
☐ EKG–*date:*_____
☐ Other–*specify test and date:*_____

In the past have you ever been seen by a medical doctor? ***If YES please check box & list name, phone number and location of doctor:***

☐ Primary Medicine _____ Phone # _____
☐ Heart Specialist (Cardiologist) _____ Phone # _____
☐ Lung Specialist (Pulmonologist) _____ Phone # _____
☐ Nerve Specialist (Neurologist) _____ Phone # _____
☐ Other: *(specify)* _____ Phone # _____

Old Medical Record Waiver / Release

My signature authorizes Washington Hospital Center to request, receive, and use information obtained from my past medical records from other health care providers. This information will only be used to assess my medical condition and plan for medical care as it relates to upcoming surgery at Washington Hospital Center.

_____ _____ _____
Date authorized Patient Name *(signature)* *(print)*

Do you perform regular exercise? *If yes, what and how often:* ☐ Yes ☐ No

If no, what limits you?

Do you take herbal medications/supplements or over the counter medications? *If yes, please list:* ☐ Yes ☐ No

Do you have any allergies? (for example, drugs, food, latex, etc.) *If yes, please specify:* ☐ Yes ☐ No

Please continue Questionnaire on pg 2 (back)

PATIENT LABEL

MedStar Washington Hospital Center

PRE-OPERATIVE PATIENT QUESTIONNAIRE
(continued)

Have you had any previous surgical operation(s)? If yes, please list type of operation and the approximate year: ☐ Yes ☐ No

Have you or any of your close family had serious problems with anesthesia? ☐ Yes ☐ No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: *If yes please check box*

☐ Chest pain, heart attack or other heart problems
☐ Heart irregularities or palpitations
☐ High blood pressure
☐ Heart surgery or angioplasty
☐ Heart pacemaker: Type_____ Model_____
☐ Abnormal ECG
☐ Asthma or wheezing ☐ Home oxygen
☐ Lung problem or abnormal chest X-ray
☐ Seizures or epilepsy
☐ Chronic cough
☐ Stroke or intermittent numbness or blackouts
☐ Do you take blood thinners? (including aspirin/ASA)
☐ Frequent fainting or dizziness
☐ Do you smoke? If so how much?_____
☐ Do you drink alcohol? If so how many drinks a week?_____
☐ Shortness of breath walking and/or climbing stairs
☐ Heartburn or hiatus hernia or acid reflux
☐ Involuntary weight loss ((10–12 pounds in 6 months)
☐ Stomach ulcers
☐ Skin sore / open wound–*location:*_____
☐ Back trouble, fractures or herniated disk
☐ Diabetes–accucheck range:_____ A1C_____
☐ Kidney/bladder/urination problems
☐ Liver problems
☐ Hepatitis or positive HIV test
☐ Rheumatoid arthritis
☐ Thyroid problems
☐ Prior bleeding or clotting disorders
☐ Severe snoring, or sleep apnea (stopping breathing while asleep)
☐ Chronic pain
☐ Do you have a history of substance abuse? How long in recovery?_____
☐ Possibility of pregnancy? Last menstrual period_____
☐ Do you have difficulties opening your mouth or moving your neck?
☐ Do you have problems swallowing?

Do you take any medication? ☐ Yes* ☐ No **If yes, please list the name, dosage, and how many times taken per day of all medications:*

Name of Medication	Dosage	# times per day	Name of Medication	Dosage	# times per day

Do you have any significant limitations? ***If yes, please check all applicable:*** ☐ glasses ☐ cane ☐ crutches ☐ walker ☐ wheelchair
☐ hearing aid ☐ problems speaking ☐ help with dressing ☐ meals ☐ getting out of bed ☐ spinal cord injury
☐ other *(specify)* _____

Will you accept a blood transfusion if needed? ☐ Yes ☐ No

Do you have any serious illnesses that we have not mentioned? If yes, please list: ☐ Yes ☐ No

I attest the above information is correct to the best of my knowledge.

Confirmation by person completing this form:

*Signature*_____ *Print Name*_____ *Date* ____ / ____ / _____

Form completed by: ☐ Patient ☐ Relative (specify *relationship to patient:*_____)

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