Orthopaedic Associates Surgery Center, LLC

PATIENT LABEL

Pre-operative Information

Last Name_____ First Name_____ Middle Initial _____ Nickname_____ Male ☐ Female ☐

Who will accompany you on the day of your surgery?_____

Home Phone (_____)_____ May we leave a message at this phone number? Yes ☐ No ☐

Cell Phone (_____) _____ May we leave a message at this phone number? Yes ☐ No ☐

Work Phone (_____) _____ May we leave a message at this phone number? Yes ☐ No ☐

Type of Surgery **(LEFT or RIGHT)** _____ Date of Surgery_____
CIRCLE ONE

ALLERGIES: Medicines_____ Other _____

Latex _____ Foods (bananas, papaya, kiwi, tomatoes, raw potatoes, avocados, chestnuts, soybeans, eggs, shellfish, other) _____

Are you taking any of the following anticoagulant/blood thinner medications? (Aspirin, Coumadin, Heparin, Plavix, Celebrex, Vioxx, Ibuprofen, Motrin, Advil, Orudis, Lovenox, Arixtra, Fragmin, Vitamin E, etc.)

_____

Do you use any of the following: Herbal Supplements: Yes ☐ No ☐ Eye Drops: Yes ☐ No ☐ Laxatives: Yes ☐ No ☐

SURGICAL HISTORY: (List most recent first)

Previous Surgeries/Year	Previous Surgeries/Year

Have you or any family members had any problem with past surgeries (difficult intubation, nausea/vomiting, history of malignant hyperthermia, fever, other complications with anesthesia)? _____

_____

Do you have any medical problems in the following areas?

Head Yes ☐ No ☐ Legs Yes ☐ No ☐ Abdomen Yes ☐ No ☐

Neck Yes ☐ No ☐ Arms Yes ☐ No ☐

Explain all Yes answers _____

Approximate date of your last **CHEST XRAY**_____ Where was it taken_____

Were the results normal ☐ or abnormal ☐

Approximate date of your last **EKG**_____ Where was it done _____

Were the results normal ☐ or abnormal ☐ Cardiologist _____

Who is your primary care physician? _____

Primary Care Physician's Phone Number _____

Date of Last Physical exam _____

TO BE COMPLETED BY PRE-OP SCREENING NURSE: Pt. has executed Advance Directive for Health Care: Yes ☐ No ☐
Pt. requests information re: Advance Directive for Health Care: Yes ☐ No ☐

HT:_____ WT:_____ B/P:_____ P:_____ R:_____ SPO2:_____ Temp: _____

Type of Anesthesia: General____ Regional Block (axillary, infraclavicular, ankle, wrist, etc.)____ Local w/ MAC____

Local w/ IV Sedation____ Local____ General w/ Interscalene Block____ Spinal____ Other _____

* See Medication Reconciliation Form for current medications.

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK AND DESCRIBE AS NEEDED:

NEUROLOGICAL
- ☐ Dizzy spells, motion sickness
- ☐ Frequent headaches, migraines
- ☐ Epilepsy, seizures
- ☐ CVA, stroke, TIA
- ☐ Parkinson's disease
- ☐ Alzheimer's disease
- ☐ Head or spinal injury or surgery
- ☐ Myasthenias gravis
- ☐ Paralysis
- ☐ Polio
- ☐ Anxiety or depression

GASTROINTESTINAL
- ☐ Reflux
- ☐ Hiatal hernia
- ☐ Ulcers
- ☐ Colon problem
- ☐ Liver disease

GENITO-URINARY
- ☐ Kidney disease, kidney stones
- ☐ Renal failure, dialysis
- ☐ Bladder disease
- ☐ Burning with urination
- ☐ Prostate problems
- ☐ Endometriosis

INTEGUMENTARY
- ☐ Current skin rash
  – Location_____
- ☐ Current injury to skin
  – Location_____
- ☐ Current treatment by Dermatologist
  – Location_____

EYES/EARS/ORAL
- ☐ Glasses, contact lenses
- ☐ Hearing Aids
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Meniere's disease
- ☐ TMJ
- ☐ Loose teeth, chipped teeth
- ☐ Caps, crowns, bridgework
- ☐ Braces
- ☐ Dentures
- ☐ Broken facial bones
- ☐ Nose or jaw surgery

PULMONARY
- ☐ Lung disease
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ COPD
- ☐ Bronchitis
- ☐ Recent cough or cold
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Snoring, obstruction

COMMUNICABLE DISEASES
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Cirrhosis
- ☐ HIV positive
- ☐ AIDS
- ☐ Tuberculosis
- ☐ MRSA, draining open wound

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid disorders, goiter

CARDIOVASCULAR/BLOOD DISORDERS
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Dysrhythmia
- ☐ Aneurysm
- ☐ Chest pain
- ☐ Angina
- ☐ Heart attack
- ☐ Cardiac catheterization
- ☐ Cardiac stents: Drug-eluting or Bare-metal
- ☐ Peripherial vascular disease
- ☐ Congestive heart failure
- ☐ Peripheral edema
- ☐ Bleeding disorder – Type:_____

MUSCULO-SKELETAL
- ☐ Back or neck problems, including previous surgery, fractures, painful positions
- ☐ Implants or artificial Joints
- ☐ Arthritis
- ☐ Bone infection
- ☐ Gout
- ☐ Osteoporosis

CANCER HX
- ☐ Cancer – Type:_____
- ☐ Leukemia

PLEASE ANSWER THE FOLLOWING QUESTIONS THOROUGHLY:

1. When you climb two flights of stairs nonstop, do you have shortness of breath? _____ Do you have chest pain?_____
2. If you have high blood pressure, when were you diagnosed with high blood pressure? _____
3. What medications are you taking to treat high blood pressure?_____
4. Do you currently smoke? _____ Amount/day _____
5. Have you ever smoked in the past? _____ Amount/day _____ For how many years? _____
6. Do you exercise? _____ Type of activity? _____ How often? _____
7. Do you have a sleep disorder? _____ Sleep Apnea? _____Or use a C-Pap machine at home? _____
8. Do you have difficulty or pain with opening your mouth widely or tilting your head back to look above you? _____
9. Asthma, wheezing: Last attack: _____, Medications taken for Asthma treatment _____
10. Do you drink alcohol? _____ Type and amount/day_____
11. Do you use any recreational drugs (marijuana, cocaine, heroin, etc.)? _____
12. Have you ever taken Redux or Phen-Phen or any other diet pills? _____Type and when? _____
13. Have you visited the Emergency Room within last year? _____ Reason for visit? _____
14. Recent weight loss? _____ Amount of weight lost? _____Recent diet? _____Type? _____
15. Have you been exposed to an infectious disease in the last two weeks? _____
16. Have you ever had a blood transfusion? _____ If so, when?_____
17. Do you have a bleeding disorder, sickle cell disease, clotting abnormalities, phlebitis, including easy bruising or excessive vaginal bleeding? _____
18. Are your immunizations current? _____ Have you ever had Hepatitis immunizations?_____

For Females: Are you pregnant: yes ☐ or no ☐

Date of your last menstrual period _____

PATIENT SIGNATURE_____

DATE_____

MEDICAL TEAM

ANESTHESIA_____ DATE_____

ANESTHESIA CLASS _____ TIME_____

NURSE_____ DATE_____

TIME_____