Unity Health System

# Surgical Pretesting Patient Questionnaire

**Home Phone** _____ **Cell** _____

**Name** _____ **Work** _____ **Other** _____

**Procedure** _____

**Operative Side (check if applicable)** ❑ Right ❑ Left **Pretesting Staff procedure verification initials** _____

**Any Serious Illnesses or Hospitalizations within the Past Year?** _____

**Please List Any Previous Surgeries and Dates** _____

_____

**Do you currently or have you in the past year had home care service?** ❑ YES ❑ NO

**If so which agency?** _____

Please check all boxes that apply to you.

**1. Any problems with eyes?**

❑ None ❑ Glaucoma ❑ Cataracts

❑ Macular Degeneration

❑ Other _____

**2. Any heart problems?**

❑ None ❑ Chest Pain ❑ Irregular Heart Beat

❑ Dizziness/Fainting ❑ Poor Circulation

❑ Heart Attack ❑ Rheumatic Fever

❑ Heart Failure ❑ Heart Valve Problems

❑ High Blood Pressure ❑ Unable to lie flat

❑ Elevated Cholesterol ❑ Murmur

❑ Other _____

Heart Doctor _____ Approximate Date of last EKG. _____

Approximate Date of Cardiac Testing _____

**3. Any lung problems?**

❑ None ❑ Asthma/Wheezing ❑ Sleep Apnea

❑ Bronchitis ❑ TB/Positive Skin Test

❑ Emphysema ❑ Home Oxygen Use

❑ Pneumonia ❑ Cold in Last Six Weeks

❑ Shortness of breath

Lung Doctor _____ ❑ Other _____

**4. Any digestive problems?**

❑ None

❑ Cirrhosis ❑ Peptic Ulcer Disease
❑ Heartburn/Reflux Disease ❑ Hiatal Hernia
❑ Hepatitis
❑ Other _____

**5. Any urinary tract problems?**

❑ None

❑ On Dialysis, Schedule: ❑ S ❑ M ❑ T ❑ W ❑ TH ❑ F ❑ S
❑ Enlarged Prostate ❑ Incontinence/Overactive Bladder
❑ Kidney Stones
Kidney Doctor _____
❑ Other _____

**6. Any musculoskeletal problems?**

❑ None

❑ Osteoarthritis ❑ Low Back Pain
❑ Rheumatoid Arthritis ❑ Limited Joint Motion
❑ Fibromyalgia ❑ Trouble Opening Mouth
❑ Osteoporosis
❑ Other _____

**7. Any endocrine problems?**

❑ None

❑ Diabetes – How Controlled: ❑ Diet ❑ Oral Meds ❑ Insulin
Blood Sugar usually runs _____
❑ Thyroid problems
❑ Other _____

**8. Any neurological problems?**

❑ None

❑ Dementia or Confusion ❑ Chronic Headaches
❑ Numbness/tingling in extremities
Upper Extremity: ❑ Right ❑ Left
Lower Extremity: ❑ Right ❑ Left
❑ Seizures ❑ Stroke/Ministroke
❑ Dizziness
❑ Other _____

**9. Any history of cancer?**

❑ None

Type of cancer _____
Treatment: ❑ Surgery ❑ Radiation ❑ Chemotherapy
Comments _____

**10. Any hematological problems?**

❑ None
❑ Anemia
❑ Bleeding Tendency
❑ Sickle Cell Disease
❑ Jehovah's Witness
❑ Blood Transfusions
❑ Blood Clots
❑ Other _____

**11. Any nervous problems?**

❑ None
❑ Anxiety
❑ Panic Attack
❑ Depression
❑ Psychosis/Schizophrenia
❑ Other _____

**12. Any Skin Problems?**

❑ None
❑ **Ec**zema
❑ Psoriasis
❑ Rashes
❑ Open Sores
❑ Other _____

**13. Any problems with anesthesia?**

❑ None
❑ Previous Surgery
❑ Family history of problems with general anesthesia.
❑ Airway, intubation problems
❑ Nausea/Vomiting

**14. Social Habits?**

❑ None
❑ Alcohol use: ❑ Daily ❑ Weekly
Have you ever tried to cut down on drinking? ❑ Yes ❑ No
Has anyone expressed concern about your drinking? ❑ Yes ❑ No
❑ Smoker: # of packs per day _____ How many years? _____
❑ Ex-smoker: Date when quit _____
❑ Recreational Drug Use

**15. Pregnancy Status:**

❑ N/A
❑ Possibly Pregnant
Birth Control Method _____
Last Menstrual Period _____

Primary Care Physician _____
Date of Last Visit _____ Reason for Visit _____
Tests Done _____

Patient Signature _____ Date _____

Reviewed By _____ Date _____ Time _____

**Submit** **Save**