ORTHOSURGERY
Ιατρείο Ορθοπαιδικών Παθήσεων

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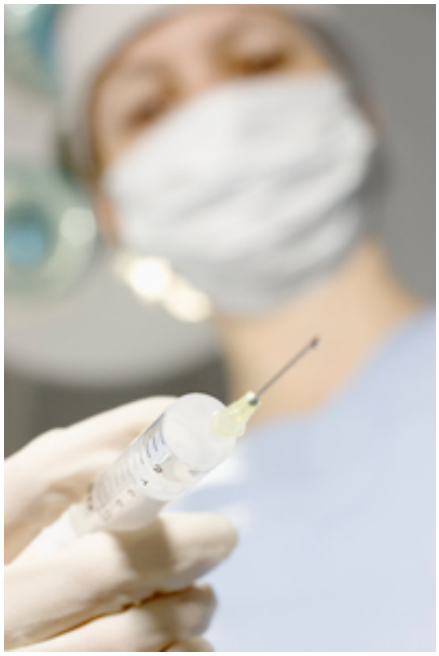
Anesthesiology Preoperative Form



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SOME THINGS TO REMEMBER:

Adults:

Adult patients must not eat or drink anything after midnight on the night before surgery. Your doctor will instruct you on the medications you may take. If your surgeon or anesthesiologist requests that you take a medication on the morning of surgery, please take it with a sip of water only. If you have trouble swallowing pills with water, please call us at UMC's Outpatient Surgery Center, and ask for advice, Monday through Friday, 9 a.m. to 5 p.m. at 806-775-8525.

You must arrange for an adult to take you home from the hospital. You cannot drive yourself home. This person should be able to act on your behalf if necessary.

Children Only:

Children may not have milk or solid food after midnight on the night before surgery. They may have clear liquids up until four hours before they are supposed to arrive at the hospital. Clear liquids include water, apple juice, Pedialyte or sugar water.

Babies should be given clear liquids up until four hours before they are supposed to arrive at the hospital. Infants should be awakened if necessary to give them some clear liquids.

Surgery Schedule:

Surgery schedules are difficult to estimate. Unexpected delays occur and waits may be unavoidable. Please plan to be in the Outpatient Surgery Center all day.

Illness:

Fever, colds or other conditions may cause problems during your surgery. If you become ill prior to the day of your surgery, please call us at Outpatient Surgery Center, so that we can make sure that you are ready for surgery. You may call 806-775-8525, Monday through Friday, 9 a.m. to 5 p.m. After hours please notify your surgeon.

OUR GOAL IS TO PROVIDE YOU WITH VERY GOOD CARE

Please answer the following questions. Please circle **Yes** or **No** or fill in the blank, as appropriate. Place a check mark (□) beside any question that you are not sure how to answer. After completing the form please return it to the indicated party: your surgeon's office staff or the UMC outpatient staff, or the anesthesiologist.

A. Patient Information

Patient Name:_____

DOB: _____Age:_____

Date:_____

Do you have any specific concerns regarding your anesthesia?

Yes

No

Please tell us about them.

What is your surgeon going to do for you?_____

What gender are you? **(Circle one)**

Male

Female

How much do you weigh?

How tall are you?

_____

B. Healthcare Provider Information

Do you have a regular physician?

□**No**

□**Yes**

Name/Title_____Phone(___)_____

Clinic Name/Address)

Do you have a heart doctor?

□**No**

□**Yes**

Name/Title_____Phone(___)_____

Clinic Name/Address_____

C. Medications

Please list any prescription and /or non-prescription medications including vitamins, supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbs and cold medications you are currently taking.

□I am not taking any medications

Name of Medication

Dose (Strength)

How often taken (e.g. 2 x a day)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you taken aspirin containing products within the last 2 weeks?

□**No**

□**Yes**

Have you taken steroid or cortisone type drugs within the last year?

□**No**

□**Yes**

□**Yes**

Please write down the name and address of your pharmacy:

_____

_____

__

l **D. Allergies**

Are there any medication to which you have had an allergic reaction or unpleasant side-effects?

□**No**

□**Yes**

If yes, please describe in the space below. If more than space allows, please provide list to the nurse.

Name of Medication

Reaction

_____

_____

_____

_____

_____

_____

Are you allergic to any foods?

□**No**

□**Yes**

Please list the food and describe what happened when you ate that/those food items:

Food Reaction

_____

_____

Are you allergic to anything else such as tape or iodine?

□**No**

□**Yes**

E. Systems Review & Past Medical History

Breathing Problems:

- Do you have any problems with breathing?

Yes

No

- Asthma?

Yes

No

- Emphysema or bronchitis?

Yes

No

- Have you had a cold within the last month?

Yes

No

If so, how long ago did you start to feel better?_____

- How many years have you smoked?_____

- Do you use oxygen at home?

Yes

No

Heart or Blood Pressure Problems:

- Have you ever been told by a doctor that you have heart disease or

That you have had a heart attack?

Yes

No

- Have you ever had chest pain?

Yes

No

- Have you ever had a study done on your heart?

Yes

No

- If yes, when did you have it done?_____

- If yes, where did you have it done?_____

- Do you have high blood pressure?

Yes

No

- How far can you walk before you get short-of-breath_____

Other Circulatory Prblems:

- Have you ever had a stroke?

Yes

No

- Do you have problems with your blood vessels?

Yes

No

- Do you bleed easily?

Yes

No

- Have you ever been told that you were anemic?

Yes

No

Other Diseases:

Do you have heartburn frequently?

Yes

No

Do you have arthritis?

Yes

No

If so, is it rheumatoid arthritis?

Yes

No

Do you have muscle disease?

Yes

No

Have you ever had a seizure?

Yes

No

- Do you have thyroid disease?

Yes

No

- Do you have diabetes?

Yes

No

- Do you have kidney disease?

Yes

No

- Do you have liver disease?

Yes

No

- Have you ever had hepatitis?

Dental Problems:

-

Do you have loose teeth?

Yes

No

-

Do you have removable dental appliances?

Yes

No

 Do you have permanently implanted dental appliances?

Yes

No

Accessories:

 Do you wear glasses or contact lenses?

Yes

No

 Do you have body piercings?

Yes

No

F. Social History

What do you do for a living? _____

How much alcohol do you consume in the average week?

_____

Have you ever smoked tobacco?

Yes

No

 If so, how many packs of cigarettes did you smoke at most during one day?

_____

Have you ever used recreational drugs?

Yes

No

G.Past Surgeries: _____

What operations have you had in the past? Please list. _____

Operation _____

Year _____

_____ _____

_____

_____

_____

_____

_____

Have you ever had a problem with anesthesia?

Yes

No

 If yes, please tell us about it.

As far as you know, has anyone in your family ever had a problem with anesthesia

Yes

No

 If yes, please tell us about it.