

STRONG MEMORIAL HOSPITAL

PROCEDURE QUESTIONNAIRE

SMH 973 MR

Page 1 of 4

- Ambulatory Surgery Unit
- Same Day Admission
- 23°
- Inpatient

Date of Procedure: _____ DOB: _____

Admission Dx: _____

Patient scheduled for: _____

Attending MD: _____

Medical Record # _____

Primary Care MD: _____

PATIENT

We want to make your stay at Strong Memorial Hospital as safe and as easy as possible. Please take a few minutes to answer the following questions. Complete as much of the following 2 1/2 pages of the form as you can. Stop at the bold line on page 3. Please do not write in shaded areas. If you have any difficulty filling out this form, a nurse from the Preadmission Evaluation Center at Strong will help you.

Instructions: Please fill in the blank lines and all boxes that apply:

Have you ever been hospitalized or treated at Strong Memorial Hospital? Yes No Year _____

Name of person completing form: _____ Date: _____ Relation to Patient: _____

A. I have the following allergies to Medications, Food or Latex: None

ALLERGIC TO	REACTION(S)
Example: Phenergan	rash

ALLERGIC TO	REACTION(S)

B. I take the following Medications: (prescriptions, over the counter, vitamins, herbs) I do not take any medications

MEDICATION	DOSE	HOW OFTEN
Example: Colace	100 mg	one in AM

MEDICATION	DOSE	HOW OFTEN

Smoking History

1) Have you smoked at least 100 cigarettes in your whole life? Yes No

If Yes: please answer questions 2 & 3

2) Have you smoked ANY cigarettes during the 3 months before your cycle began? Yes No

3) The number of cigarettes you've smoked on average during the 3 months before your cycle? _____

Beta-blocker Protocol Implemented; Date: _____
Recommended Post-op Duration 1-2 Weeks

C. I have had the following Surgeries: I have never had surgery

YEAR	SURGERY	ANESTHESIA	COMPLICATIONS
Example: 1947	Appendectomy	1. General 2. Spinal/Epid 3. Local/block	Nausea

YEAR	SURGERY	ANESTHESIA	COMPLICATIONS

D. A family member had a reaction to anesthesia. Relation: _____ Reaction: _____ No Reaction

<p>I have the following: <input type="checkbox"/> None</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Loose teeth; broken teeth <input type="checkbox"/> Caps or crowns <input type="checkbox"/> Dentures/partials </div> <div style="width: 45%;"> <input type="checkbox"/> Glasses/contact lenses <input type="checkbox"/> Hearing aids </div> </div>	<p><i>THIS COLUMN FOR STAFF USE ONLY</i></p>
<p><input type="checkbox"/> I do not speak and understand English. <input type="checkbox"/> English speaking I speak a language other than English: _____ <input type="checkbox"/> I am hearing impaired.</p>	
<p>I have used <input type="checkbox"/> CIGARETTES <input type="checkbox"/> PIPE <input type="checkbox"/> CIGAR <input type="checkbox"/> CHEW <input type="checkbox"/> Never</p> <p><input type="checkbox"/> I smoke _____ packs a day for _____ years. <input type="checkbox"/> I quit smoking _____ years ago. I used to smoke _____ packs a day for _____ years.</p>	
<p>I have had the following RESPIRATORY illnesses: <input type="checkbox"/> None</p> <input type="checkbox"/> Cold or other respiratory infection within last month <input type="checkbox"/> Chronic obstructive pulmonary disease (emphysema or chronic bronchitis) <input type="checkbox"/> Asthma <input type="checkbox"/> I use home oxygen <input type="checkbox"/> My breathing is not at its best <input type="checkbox"/> My breathing limits my physical activities <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Pneumonia: I was treated _____ <input type="checkbox"/> Tuberculosis: I was treated _____ <input type="checkbox"/> Other: _____	
<p>I have had the following HEART illnesses: <input type="checkbox"/> None</p> <input type="checkbox"/> High blood pressure for _____ years <input type="checkbox"/> Arrhythmia, irregular heart beat, or palpitations <input type="checkbox"/> These make me dizzy or lose consciousness <input type="checkbox"/> Chest pain, heaviness, pressure, or tightness <input type="checkbox"/> Angina <input type="checkbox"/> Its duration or intensity have recently changed <input type="checkbox"/> Heart attack(s) Date(s) _____ <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Coronary angioplasty or stent <input type="checkbox"/> Heart valve disease or murmur <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Other heart valve disease <input type="checkbox"/> Pacemaker <input type="checkbox"/> High cholesterol <input type="checkbox"/> Automatic implantable cardioverter defibrillator (AICD) <input type="checkbox"/> I have seen a cardiologist or had cardiac testing: <input type="checkbox"/> Other: _____	<p>FH -</p>
<p>Physical ACTIVITIES: <input type="checkbox"/> No limitations</p> <p>I have trouble breathing or get chest pain when I:</p> <input type="checkbox"/> Climb one flight of stairs <input type="checkbox"/> Do heavy work around the house like scrubbing floors <input type="checkbox"/> Other: _____ <p>I regularly participate in physical exercise/activities:</p>	
<p>I have had these GASTROINTESTINAL problems: <input type="checkbox"/> None</p> <input type="checkbox"/> Heart burn or acid reflux (GERD - Gastroesophageal Reflux Disease) <input type="checkbox"/> Stomach or duodenal ulcers <input type="checkbox"/> Bowel problems <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Liver failure <input type="checkbox"/> Other: _____	
<p>I have had the following BLEEDING problems: <input type="checkbox"/> None</p> <input type="checkbox"/> Frequent nosebleeds or large bruises <input type="checkbox"/> Blood clots <input type="checkbox"/> Von Willebrands Disease <input type="checkbox"/> Anemia <input type="checkbox"/> Hemophilia <input type="checkbox"/> I have family members with bleeding disorders <input type="checkbox"/> Other: _____	
<p>I have had KIDNEY diseases: <input type="checkbox"/> None</p> <input type="checkbox"/> Kidney failure or abnormal kidney function <input type="checkbox"/> I use peritoneal dialysis <input type="checkbox"/> I use hemodialysis on the following days: _____ <input type="checkbox"/> Stones <input type="checkbox"/> Other: _____	
<p>I have had the following JOINT problems: <input type="checkbox"/> None</p> <input type="checkbox"/> Arthritis: <input type="checkbox"/> Osteo (degenerative) <input type="checkbox"/> Rheumatoid Where? <input type="checkbox"/> Other: _____	
<p>I have had PSYCHIATRIC disorders such as: <input type="checkbox"/> None</p> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Other: _____	

I have had these ENDOCRINE illnesses: <input type="checkbox"/> None <input type="checkbox"/> Thyroid <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Other: _____	<i>THIS COLUMN FOR STAFF USE ONLY</i>
I have had these NERVE OR MUSCLE illnesses: <input type="checkbox"/> None <input type="checkbox"/> Transient ischemic attack (TIA) <input type="checkbox"/> Stroke <input type="checkbox"/> I have continued weakness or numbness: <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Myasthenia gravis <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Malignant hyperthermia <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____	FH -
I have used the following: <input type="checkbox"/> None <input type="checkbox"/> Alcohol: I drink (how many) _____ drinks per _____ <input type="checkbox"/> Recreational/Street drugs: types - _____ I use these every _____ days/weeks/months. Date of last use: _____	FH -
<input type="checkbox"/> There is a chance I may be pregnant. <input type="checkbox"/> Not pregnant Date of last menstrual period: _____	
<input type="checkbox"/> I have the following conditions not listed above (e.g., cancer): <input type="checkbox"/> None _____ _____ _____ _____	

Vital Signs: BP _____ P _____ RR _____ T _____ °C ht _____ in. wt _____ kg Room Air O₂ sat _____

RN Assessment: Above information reviewed and assessed by: _____ RN Date _____

ANESTHESIA ASSESSMENT

PROBLEM LIST / SUMMARY:

PHYSICAL EXAM:

BMI: _____

	Yes	No			
Mental:	<input type="checkbox"/>	<input type="checkbox"/>	Alert/Oriented Other:		
Airway:	I	II	III	IV	Class
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck Extends Well
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyro-Mental Distance Adequate
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Opening Adequate
Lungs	<input type="checkbox"/>	<input type="checkbox"/>			Dentition: Clear to Auscultation Other:
Heart	<input type="checkbox"/>	<input type="checkbox"/>			Regular Rate & Rhythm No Murmur Other:

Labs:

EKG:

Other:

PLAN PER ANESTHESIOLOGIST:

Beta blocker protocol initiated/continued

PHYSICAL STATUS 1 2 3 4 5 6 E

Anesthetic options discussed:

Anesthetic risks discussed: Nausea, vomiting, sore throat, dental injury, airway problems, eye injury, allergic reaction, nerve injury, unexpected serious injury / death

Invasive monitoring discussed: Arterial line Central Venous Line Pulmonary Artery Catheter Transesophageal Echocardiogram

Medication instruction:

NPO Advised: Department of anesthesiology guidelines

NPO confirmed:

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Page 4 of 4

Medical Record # _____

PHYSICAL EXAM: MD NP See Chart

HPI:

HEENT:

normal PERRL, red reflex present bilaterally EOMI. Oropharynx non-infected. No adenopathy. No thyromegaly.
TM: _____ Carotid: _____

abnormal

NECK: normal (full range of motion)

supple abnormal

Airways class:

Male

Last rectal / prostate exam _____

Rectal: Defer to admission

Defer to 1° MD

Done - results

Lungs / Thorax / Breasts: normal: clear all fields anterior & posterior

abnormal

Female

Last Pap / Rectal _____

Last Mammogram _____

Heart: normal: RRR S1S2 without MRG

Abdomen: normal: soft, non-tender, 0 masses, 0 organomegaly, 0 bruits. Bowel sounds x 4 quadrants

abnormal

Extremities: normal: pink, warm, 0 edema

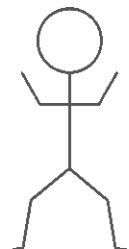
abnormal

	Fem	POP	PT	DP	Rad	Brac
R						
L						

Neurologic: normal: Alert & Oriented x 3, speech clear, sensation intact, gait sturdy

strength: _____ Cranial Nerves: _____

abnormal



Assessment / Plan: NPO per policy Questions answered Preoperative teaching Transportation home

MD/Resident/NP Signature

Date/Time

Attending Surgeon

Date / Time

KEY: Fem - Femoral

PT - Posterior Tibial

EOMI - Extra Ocular Motions Intact

PERRL - Pupils Equal Round React to Light

RRR - Regular, Rate Rhythm

FH - Family History

POP - Popliteal

DP - Dorsalis Tibial

MRG - Murrur Rub or Gallop

Rad - Radial

Brac - Brachial

TM - Tympanic Membrane