Pre-Surgical Screening
Health Assessment Form
All information will remain confidential

Name ______________________________ Age ______ Date of Birth __________ ☐ Female ☐ Male
Home Phone # ________________ Work Phone # ________________ Cell Phone # ________________
Emergency Contact _________________________ Relationship ______________ Phone # __________
Height ______ Weight ______ Primary Language ☐ English ☐ Spanish ☐ Other ____________________
Primary Care Physician _________________________ Cardiologist ____________________________

☐ No Changes Since Previous Visit in Last 3 Months

Drug	Dose	Frequency	Indication

	Yes	No	Don't Know	Explain
Have you taken Prednisone or other steroids in the past 3 months?				
Allergies				
Do you have allergies to medications, latex, metal, or food?				
Anesthesia				
Have you ever had a problem with anesthesia including malignant hyperthermia or difficult intubation?				
Has any family member had a problem with anesthesia?				
Loose, capped, or broken teeth; bridges or dentures?				
Trouble opening mouth or jaw clicking?				
Do you have shortness of breath or chest discomfort after walking up 1 flight of stairs?				
Do you use home oxygen?				
Do you smoke?				
Are you an ex-smoker?				
Do you drink alcoholic beverages?				
Do you use any street drugs?				
Have you had a blood transfusion within the last 6 months?				
Do you have religious restrictions or other objections to receiving blood transfusions?				

	Yes	No	Don't Know	Explain
Do you have an Advanced Directive/Living Will?				
Do you have a Do Not Resuscitate (DNR) Order?				
Females Only 1. Are you nursing? 2. Are you menopausal or had a hysterectomy/tubal?				

Health Conditions (*Check all that apply*)

Cardiac
- ☐ Abnormal EKG
- ☐ Congestive Heart Failure (CHF)
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Rheumatic Heart
- ☐ Coronary Artery Disease
- ☐ Chest Pain
- ☐ Rhythm Disturbances
- ☐ Edema/Swelling
- ☐ Heart Stents

Bleeding Circulation
- ☐ Anemia
- ☐ Bleeding Tendency
- ☐ Blood Clots
- ☐ Poor Circulation
- ☐ Sickle Cell
- ☐ Varicose Veins
- ☐ Pulmonary Embolism
- ☐ Deep Vein Thrombosis (DVT)

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ COPD
- ☐ Use CPAP machine
- ☐ Snoring
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ Smoker
- ☐ Tuberculosis (TB)
- ☐ Use of Oxygen

Gastrointestinal
- ☐ Recurrent Gastric Reflux
- ☐ Hernia
- ☐ Ulcers
- ☐ Diverticular Disease
- ☐ Irritable Bowel Syndrome
- ☐ Colitis
- ☐ Crohns Disease
- ☐ Difficulty Swallowing
- ☐ Bulimia

Endocrine
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Cirrhosis
- ☐ Thyroid Problems
- ☐ Goiter
- ☐ Adrenal Disease

Genitourinary
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Prostate Problem
- ☐ Urinary Tract Infection
- ☐ Dialysis

Skin
- ☐ Rashes
- ☐ Bruise Easily
- ☐ Sore/Open Areas
- ☐ Psoriasis
- ☐ Eczema

Musculoskeletal
- ☐ Arthritis
- ☐ Limited Movement
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy

Neurological/Mental Health
- ☐ Stroke
- ☐ Mini Stroke (TIA)
- ☐ Seizures
- ☐ Migraine headaches
- ☐ Alcoholism
- ☐ Chemical dependency
- ☐ Myasthenia Gravis
- ☐ Depression/Anxiety
- ☐ Dementia
- ☐ Parkinson's tremors

Infectious Diseases
- ☐ Recent mononucleosis (mono)
- ☐ HIV
- ☐ Hepatitis – A, B, C
- ☐ Herpes
- ☐ MRSA
- ☐ C Diff
- ☐ VRE
- ☐ ESBL

Implantable Devices
- ☐ Ports/Pumps
- ☐ Surgical Hardware
- ☐ Dental Implant
- ☐ Cataract Implant
- ☐ Pacemaker/ ICD
- ☐ Other (list)

Important! Bring implant card with you.

Cancer or Tumor
- ☐ None
- ☐ Type ______________
- ☐ Chemo______________
- ☐ Radiation ___________
- ☐ Name of oncologist:

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Have you been hospitalized for any of the above conditions? *Explain*

Surgical History (*Check all that apply*)

- ☐ No prior surgery
- ☐ Appendectomy
- ☐ Angioplasty
- ☐ Arthroscopy
- ☐ Breast biopsies
- ☐ Cataract
- ☐ Cardiac bypass/CABG
- ☐ Colonoscopy
- ☐ D&C
- ☐ Gallbladder
- ☐ Heart catheterization/Stent
- ☐ Heart valve replacement
- ☐ Hemorrhoidectomy
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Implanted defibrillator
- ☐ Kidney removal
- ☐ Mastectomy
- ☐ Pacemaker
- ☐ Prostate
- ☐ Splenectomy
- ☐ Spine (back/neck)
- ☐ Tonsils & adenoids
- ☐ Total knee L R
- ☐ Total hip L R
- ☐ Tubal ligation
- ☐ Other (list):

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***Please Fill Out this Form and Be Ready to Discuss the Information with the Pre-Admissions Nurse.**