NewYork-Presbyterian

50705

MRN#:

NAME:

DOB: SEX:

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

PRE-PROCEDURE SCREENING TOOL

Please print clearly

Name:_____ MRN:_____

Date of Birth:_____/_____/_____ Age:_____ Gender (circle one): M / F

Your E-mail:_____ Preferred Phone: ( )_____-_____

Best time to call:_____ May we leave a message (circle one)? Yes / No

Preferred language:_____ Do you need a translator on the day of surgery (circle one)? Yes / No

Do you have sight and/or hearing impairment (circle one)? Neither / Sight / Hearing / Both

Surgeon (full name):_____ Expected Date of Surgery: _____/_____/_____

Expected procedure: _____

Primary Care Physician (full name):_____ Phone: ( )_____-_____

Cardiologist (full name):_____ Phone: ( )_____-_____

Height (in feet and inches):_____ Weight (in lbs.):_____

Please list all current medical conditions:

Please list all allergies (medication, food) and reaction:

Please list all medications you are currently taking (including herbal supplements) and dose:

Please list all prior surgeries and dates:

Please check the boxes below to indicate if you have experienced any of the following problems with prior surgery or anesthesia (you may select more than one):

☐ Severe nausea/vomiting ☐ Problems placing breathing tube ☐ Nerve injury ☐ Slow wake up after anesthesia

☐ Personal/Family history of Malignant Hyperthermia ☐ Other:_____

Do you... ?	How much/often?	How many years?	If applicable, date quit?
Smoke cigarettes?			
Drink alcohol?			
Use recreational drugs?			

☐ I'd prefer to answer in person

IMPLANTS (please bring your wallet card on the day of surgery):

Do you have a pacemaker or an internal defibrillator (circle one)? Yes / No Brand?_____ Last check-up?_____/_____/_____

Do you have an artificial heart valve (circle one)? Yes / No ☐ Biologic valve ☐ Mechanical Valve

Do you have any implantable devices (check all that apply): ☐ PICC ☐ Broviac ☐ Dialysis catheter ☐ Fistula ☐ Ventricular device

☐ Insulin pump ☐ Other:_____

50705 (10/16)

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PRE-PROCEDURE SCREENING TOOL

Please print clearly

Please answer the following questions by putting a check mark in the appropriate box (Yes or No):

	Yes	No
Have you ever had a heart attack or cardiac bypass operation?		
Do you have stents in any artery in your brain or body?		
If yes, please ask your surgeon to complete the *Stent Letter*		
Do you have high blood pressure?		
Have you been diagnosed with congestive heart failure?		
Do you have atrial fibrillation or atrial flutter?		
Do you get short of breath or have chest pain when you walk up 1 flight of stairs or 2 city blocks?		
Do you have COPD or Asthma?		
Do you use a rescue inhaler (Albuterol) more than twice a week?		
Hospitalized for COPD/Asthma attack?		
Do you use supplemental oxygen at home?		
Have you been diagnosed or suspected to have Obstructive Sleep Apnea (OSA)?		
Do you use a BiPAP or CPAP machine at home?		
Do you have trouble lying flat on your back?		
If yes: ☐ because of pain ☐ because of breathing difficulty		
Do you have abnormal kidney function?		
Are you on Dialysis?		
Do you have Diabetes?		
Do you take insulin?		
Do you have? ☐ HIV? ☐ Hepatitis A? ☐ Hepatitis B? ☐ Hepatitis C?		
Have you been diagnosed with cirrhosis?		
Have you ever had a seizure?		
Have you ever had a stroke or surgery on your carotid arteries?		
Do you have any chronic pain that requires daily medication?		
Have you had chemotherapy for cancer?		
Have you ever had radiation to your neck or throat?		
Have you ever had a tracheostomy (an incision in windpipe for breathing)?		
Do you have trouble opening your mouth or looking up at the ceiling?		
Have you traveled outside of the US in the last two months? Where?_____		
Have you ever had a blood transfusion?		
Do you have an objection to blood transfusion if medically necessary?		
Have you been diagnosed with a bleeding disorder?		
Do you have problems with excessive bleeding after surgical or dental procedures?		
If you are a woman of childbearing age, are you or do you believe you may be pregnant?		

Patient/Representative Signature:_____ Date:_____ /_____ /_____ Time:_____AM/PM

*****CLINICIAN USE ONLY*****

- If 1 or more of the bold boxes are checked AND the patient is undergoing high or intermediate risk surgery, it is recommended that the patient has a baseline EKG.
- If 2 or more of the bold boxes are checked, the patient should also be referred to their PMD/Cardiologist or the Anesthesiologist in Pre-Admission Testing.