PLACE PATIENT LABEL HERE

UNIVERSITY of MARYLAND FACULTY PHYSICIANS, INC.
Faculty Practices of the University of Maryland School of Medicine

Waterloo Preoperative Clearance

Patient Questionnaire

Date: _____

Dear Patient,
This questionnaire will help your pre-operative clearance team determine what if any preoperative work up will be needed prior to your surgery and help them gather all available medical information about you. Please fill it out as best you can. This information will help to avoid any delay in your surgery. If you have any questions, you can contact us at **667-214-2100 option 1.** Thank you!

Name: _____ Person Completing Form: _____ Title: _____

Age: _____ Height: _____ Weight: _____ Date of Birth: _____

Surgeon: _____ Proposed Surgery: _____

Proposed date of surgery: _____

1. **Your contact information:**

   Home phone: _____ Work phone: _____

   Cell phone or pager: _____ E-mail address: _____

   Best time to reach you: AM PM (circle)

   Best way to reach you: home work cell/pager e-mail (circle)

2. **Do you have a primary care doctor?** Yes No (circle)

   Name: _____

   Address and phone number: _____

3. **Do/Did you ever smoke?** Yes No (circle)

   How many packs per day? _____
   How many years? _____
   If applicable, when did you quit? _____

4. **Do/Did you ever drink alcohol?** Yes No (circle)

   How often? _____
   How much? _____
   If applicable, when did you quit? _____

5. **Do/Did you ever use "street" drugs?** Yes No (circle)

   What drug? (circle) Cocaine Heroin Other: _____
   Did you ever use IV drugs? Yes No (circle)
   If applicable, when did you quit? _____

Please use the last page of this questionnaire to list all your medications, including over-the-counter herbals and vitamins, as well as "as needed" medications.

Patient Name: _____ Date of Birth: _____

6. Do you have any allergies to medications? Yes No (circle)

Drug: _____ What happens? _____
Drug: _____ What happens? _____
Drug: _____ What happens? _____
Drug: _____ What happens? _____

7. Do you have any allergies to substances other than medications? Yes No (circle)
(Circle all that apply)

Betadine/Iodine	Latex	Eggs	Other: _____
Gadolinium	IV contrast	Tape	

8. List all the surgeries you have had in the past (most recent first).
(Use back of page for additional information)

Year: _____ Surgery: _____ Hospital: _____
Year: _____ Surgery: _____ Hospital: _____
Year: _____ Surgery: _____ Hospital: _____
Year: _____ Surgery: _____ Hospital: _____

9. Have you or anyone related to you ever had a major complication that was related to receiving anesthesia? Yes No (circle)

10. Have you had blood drawn for testing in the past three months? Yes No (circle)

Date: _____ Place: _____

11. Have you had a chest x-ray in the past year? Yes No (circle)

Date: _____ Place: _____

12. Have you ever had an EKG done? Yes No (circle)

Date: _____ Place: _____
Date: _____ Place: _____

13. Have you ever had any heart problems (for example, congestive heart failure, angina (chest pain), heart attack, arrhythmia)? Yes No (circle)

Date: _____ Problem: _____ Hospital: _____
Date: _____ Problem: _____ Hospital: _____
Date: _____ Problem: _____ Hospital: _____

14. Do you have an Automatic Internal Cardiac Defibrillator (AICD) or pacemaker? Yes No (circle)
If "Yes", do you know the model and the name of the maker?
Model _____ **Company** _____
(Please bring your device pocket card with you to the hospital.)

15. Have you ever had any special heart tests? (for example, stress tests, echocardiograms, cardiac catheterization) Yes No (circle)

Date: _____ Test: _____ Place: _____
Date: _____ Test: _____ Place: _____
Date: _____ Test: _____ Place: _____

Patient Name: _____ Date of Birth: _____

16. **Can you climb one flight of stairs without stopping?** Yes No (circle)

17. **Please describe your physical activities.** (i.e. exercise often, run regularly, play tennis, able to mow lawn, poor exercise tolerance, get short of breath frequently, mostly sitting down throughout the day) _____

18. **Have you ever been diagnosed with any of the following (circle all that apply):**

Peripheral vascular disease	Bleeding or clotting problems	Stroke or mini stroke
Kidney disease	Asthma	Tuberculosis
Emphysema	GERD/Reflux/Heartburn	Hiatal hernia
Cancer	Hepatitis	Cirrhosis
Seizure	Diabetes	Thyroid problems
HIV/AIDS	High Blood Pressure	

19. **Specialists you are currently seeing or have seen in the past five years:**
(You do not need to list your surgeon for the proposed procedure here).

Cardiologist Name: _____ Phone: _____

Pulmonologist Name: _____ Phone: _____

Nephrologist Name: _____ Phone: _____

Hematologist Name: _____ Phone: _____

Oncologist Name: _____ Phone: _____

Other Name: _____ Specialty: _____ Phone: _____

Other Name: _____ Specialty: _____ Phone: _____

20. **Have you been diagnosed with obstructive sleep apnea?** Yes No (circle)
Do you use CPAP/BiPAP? Yes No (circle)
Have you had a sleep study? Yes No (circle)

Date: _____ Place: _____

21. **Are there any specific things you would like your pre-operative examining physician to know?**

Patient Name: _____ Date of Birth: _____

Medication List

Please use this sheet to list out your medications. Please include vitamins, minerals, herbal supplements and other over the counter (OTC) medicines that you take even if they were not prescribed by your doctor. It is important to list everything you take even if you only take them once in a while or if only as needed. We need to know because it may affect you during and after surgery and some medicines (even herbal supplements) can interact with other medications you receive during your hospital stay. If you are not sure about your medication or pills, bring everything with you when you come in, so that the nurse or doctors can review them with you.

Name of medicine, vitamin or supplement	How much do you take? (Tablets and milligrams, if you know)	How often do you take this medicine? (once a day, or more or less often)	What is the reason you are you taking this medicine?
1.			
2.			
3.			
4.			
5.			
6.			
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18.			
19.			
20.			