**Patient Name:** _____ **MRN:** _____

UB|MD PRIMARY CARE

# Preoperative Visit Questions

**Procedure:** _____ **Surgery Date:** _____

**Surgeon:** _____ **Fax #:** _____

## Preoperative Testing:

**Did you have the following preoperative testing completed? If so, where?**

**Location of Testing:** _____ **Bloodwork:** ☐ Yes ☐ No

**EKG:** ☐ Yes ☐ No **Chest X-Ray:** ☐ Yes ☐ No

## Pertinent Medical History:

| | | | | | | |
|---|---|---|---|---|---|---|
| Prior Anesthesia | ☐ Yes | ☐ No | | Sleep Apnea | ☐ Yes | ☐ No |
| Prev. Anesthesia Reaction | ☐ Yes | ☐ No | | Clotting Disorder | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | | Bleeding Disorder | ☐ Yes | ☐ No |
| Heart Disease | ☐ Yes | ☐ No | | Transfusion Reaction | ☐ Yes | ☐ No |
| Lung Disease | ☐ Yes | ☐ No | | Impaired Immunity | ☐ Yes | ☐ No |
| Kidney Disease | ☐ Yes | ☐ No | | Steroid Use in Last 6 Months | ☐ Yes | ☐ No |
| GI Disease | ☐ Yes | ☐ No | | Frequent Aspirin Use | ☐ Yes | ☐ No |

## Family History:

| | | | | | | |
|---|---|---|---|---|---|---|
| Anesthesia Reaction | ☐ Yes | ☐ No | | Sudden Death | ☐ Yes | ☐ No |
| Heart Attack | ☐ Yes | ☐ No | | Clotting Disorder | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No | | Bleeding Disorder | ☐ Yes | ☐ No |
| Aneurysm | ☐ Yes | ☐ No | | | | |

TURN PAGE

**Patient Name: _____ MRN: _____**

## Social History:

| | | | | | | |
|---|---|---|---|---|---|---|
| Aspirin Use | ☐ Yes | ☐ No | | Illicit Drug Use | ☐ Yes | ☐ No |
| NSAID Use | ☐ Yes | ☐ No | | Transfusion Refusal | ☐ Yes | ☐ No |
| Tobacco Use | ☐ Yes | ☐ No | | Dentures or Partial Plates | ☐ Yes | ☐ No |
| Alcohol Use | ☐ Yes | ☐ No | | Aftercare Concerns | ☐ Yes | ☐ No |

## Personal Habits:

☐ Tobacco: _____ / Day

☐ Caffeine: _____ Cups / Day

☐ Alcohol: _____ Drinks / Day

☐ Alcohol: _____ Drinks / Week

## Planned Aftercare Setting:

☐ Home Alone

☐ Home with Home Care

☐ Home with Family

☐ Rehab Center

☐ Nursing Home

☐ Other: _____