

Internal Medicine

Preoperative Evaluation Clinic

additional details welcome

BACKGROUND

Name _____ Date of birth _____
What surgery are you having? _____ Who is your surgeon? _____
What is the date of the surgery? _____ Who is your general doctor? _____

PAST MEDICAL HISTORY

Please list all current medical problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List all surgeries and any complications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List other major illnesses or injuries:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

- Do you have any implants; such as artificial heart valves, pacemakers, or a hip prosthesis? Yes _____ No _____
- Have you ever been told to take antibiotics prior to surgery or dental work? Yes _____ No _____

MEDICATIONS

Please list your current medications. Include any birth control pills, over-the-counter medications, inhaled medications, vitamins, herbal remedies, and any recreational drugs:

ALLERGIES

Do you have a latex allergy? Yes _____ No _____
Please list all medication and food allergies with the associated reaction:

SOCIAL HISTORY

What type of work do you do? _____
Do you currently drink, or have you consumed alcoholic beverages in the past? Yes _____ No _____
If yes, what? _____ Amount? _____ How often? _____ Last time you drank? _____
Do you now or have you ever used tobacco, in any form? Yes _____ No _____
If yes, what? _____ Amount? _____ How often? _____ Last time you used it? _____
Are you at risk for HIV/AIDS (sexual orientation, IV drug use, previous blood transfusion)? _____

FAMILY HISTORY

Please circle any medical problems that run in your family (grandparents, parents, siblings, and/or children):

Arthritis	Atrial fibrillation	Blood clots	Bleeding problems
COPD/asthma/emphysema	Diabetes	Heart valve disease	Heart failure
Heart attacks	High blood pressure	Low immunity	Kidney disease
Migraines	Problems with anesthesia	Seizure	Strokes or TIAs
Thyroid disease	Tuberculosis	Cancer - Type: _____	
Other - Explain: _____			

REVIEW OF SYSTEMS - Have you experiencing problems with any of the following? Circle Yes(Y) or No(N) as appropriate:

Constitutional

Night sweats Y N
Fevers Y N
Weight loss in the past 6 months Y N
Was the weight loss intentional Y N
What is your usual weight _____ lbs

Gastrointestinal

Blood in the stool Y N
Nausea/Vomiting Y N
Liver Disease/Jaundice Y N
Ulcers/Gastritis Y N
Colon/Stomach Cancer Y N

Psychiatric/Neurologic

Anxiety/Depression Y N
Psychiatric disorder/treatment Y N
Fainting spells/blacking out Y N
Seizures Y N
Stroke/TIA/ministroke Y N

Eyes

Double vision Y N
Blurry vision Y N
Glaucoma Y N
Do you wear glasses/contacts Y N

Genitourinary

Urinary tract infection Y N
Frequent urination Y N
Prostate cancer (males) Y N
Uterine/Cervical cancer (females) Y N
Blood in the urine Y N

Endocrine

Diabetes Y N
Excessive thirst Y N
Thyroid disease Y N
Are you pregnant or breastfeeding Y N

Cardiovascular

Chest pain or angina Y N
High blood pressure Y N
Irregular pulse/A.fib. Y N
Heart murmur Y N
Coronary artery disease Y N

Musculoskeletal

Broken bones Y N
Weakness arms/legs Y N
Arthritis Y N
Gout Y N
Leg pains Y N

Hematologic/Lymphatic

Anemia Y N
Easy bleeding/bruising Y N
Swollen glands/lymph nodes Y N
Blood transfusions Y N
Blood clots Y N

Respiratory

Asthma Y N
Cough Y N
Emphysema Y N
Shortness of breath Y N
Bronchitis/Pneumonia Y N
Lung cancer Y N
Blood in the sputum Y N
Difficulty breathing Y N

Integumentary

Skin cancer Y N
Skin disease Y N
Foot/leg sores Y N

Immunologic

Immune deficiency/disorder Y N
Radiation treatment in the past Y N
Chemotherapy in the past Y N

Physical Activity

Do you exercise Y N
Please describe your highest level of exertion in the past 10 days: _____

SLEEP APNEA QUESTIONNAIRE - Please circle the best answer to numbers 1-9 and fill in your best estimate for 10 and 11:

- Do you have sleep apnea?
 - yes
 - no
 - don't know
- Do you use CPAP?
 - yes
 - no
 - don't know
- What is your snoring frequency?
 - almost every day
 - 3-4 times per week
 - 1-2 times per week
 - 1-2 times per month
 - never or almost never
- How often do you suffer from a morning headache?
 - almost every day
 - 3-4 times per week
 - 1-2 times per week
 - 1-2 times per month
 - never or almost never
- Has anyone noticed that you quit breathing during sleep?
 - almost every day
 - 3-4 times per week
 - 1-2 times per week
 - 1-2 times per month
 - never or almost never
- How often do you feel tired or fatigued after sleeping?
 - almost every day
 - 3-4 times per week
 - 1-2 times per week
 - 1-2 times per month
 - never or almost never
- Are you tired during wake time?
 - almost every day
 - 3-4 times per week
 - 1-2 times per week
 - 1-2 times per month
 - never or almost never
- Have you ever fallen asleep while driving?
 - yes
 - no
- Do you have a history of high blood pressure?
 - yes
 - no
 - don't know
- What is your weight? _____
- What is your height? _____