CENTER FOR ORTHOPEDIC ARTHROSCOPIC SURGERY & TREATMENT

Patient Label

Patient Preoperative Health Questionnaire

WHAT KIND OF ANESTHESIA HAVE YOU HAD?

YES	NO		
o	o	General	Anesthesia Complications? _____
o	o	Spinal	
o	o	Local	When? _____

WHAT KIND OF OPERATIONS HAVE YOU HAD? WHEN?

1. _____ 3. _____

2. _____ 4. _____

HEALTH HISTORY

YES	NO		YES	NO		YES	NO	
o	o	Heart Disease	o	o	Lung Disease	o	o	Diabetes
o	o	Angina, Chest Pain	o	o	Emphysema	o	o	Gluacoma
o	o	Heart Attack	o	o	Asthma	o	o	Epilepsy, stroke
o	o	Irregular heart beat	o	o	Wheezing	o	o	Emotional Problems
o	o	High Blood Pressure	o	o	Hepatitis, jaundice	o	o	Recreational Drug Use (HX)
o	o	Mitral Valve Prolapse	o	o	Kidney Problems	o	o	Latex Sensitivity
o	o	Stomach Problems	o	o	Arthritis	o	o	Shellfish Allergy
o	o	Cortisone Therapy	o	o	Back Problems	o	o	Sleep Apnea
						o	o	Headaches (HX)

YES	NO		
o	o	Do you have:	Caps?____Loose or chipped teeth?____Bridges?____Dentures? _____
o	o	Do you wear:	Contact Lens?_____Hearing Aid?_____Prosthesis? _____
o	o	Do you have difficulty opening your mouth or moving your neck?	
o	o	Do you have a cold?	
o	o	Do you drink alcohol? If so, how much: _____	
o	o	Do you smoke? If so, how much: _____	
o	o	If female, is there any possibility you are pregnant at this time?	
o	o	Any family history of unusual anesthesia reactions?_____	

LIST YOUR CURRENT MEDICATIONS: _____

_____

LIST YOUR ALLERGIES TO MEDICATIONS: _____

_____

WHEN DID YOU LAST EAT?_____LAST DRINK?_____

PATIENT SIGNATURE_____DATE _____

BP_____P_____R_____T_____HT_____WT_____ O2 SAT_____

PHYSICAL EXAM HEART_____LUNGS_____OTHER_____

ANESTHESIOLOGIST EVALUATION: _____

_____

PATIENT MEETS CRITERIA FOR ADMISSION TO CENTER/EXTENDED CARE IF ORDERED BY SURGEON YES / NO

PHYSICAL STATUS: 1 2 3 4 PLAN: GENERAL_____MAC_____REGIONAL _____

PHYSICIAN SIGNATURE_____DATE:_____TIME: _____

SAN DIEGO
HANDSPECIALISTS
CARE OF THE HAND & UPPER EXTREMITY

STATEMENT OF COMPREHENSION

INSTRUCTIONS

Read this form completely. **INITIAL** each paragraph. If you agree with the statements, **WRITE "I UNDERSTAND"** on the line *above* your signature and **SIGN** where indicated at the bottom of the page. You MUST bring these papers to our office at the time of your Pre-Operative Visit.

Dear Patient:

☐ The reasons for undertaking this operation, anticipated goals, and possible complicating factors, and alternative methods of treatment have been discussed with you previously. We feel strongly that a patient wants to know what his or her medical problem is; expressed in terms you can understand. We have, therefore, tried to explain our proposed treatment in lay terms, so that you may understand the nature of your condition and the goals of the surgical treatment you have requested. If you have any questions about your procedure, please discuss them with us.

☐ Most orthopaedic procedures are done to arrest pain, to improve function, to prevent or correct an abnormal situation. Some times an exploratory type procedure is necessary when the exact diagnosis cannot be made with the usual clinical tools available to us. Some conditions can be treated non-operatively as well as operatively - often with the same results or similar results. The operative's choice of treatment, therefore, is based on medical knowledge and experience, and the patient's understanding of the problem. We have discussed these methods with you.

☐ All forms of treatment have certain risks associated with them. Some are far more risky than others. We have attempted to explain the risks and possible complications of your proposed operation with you. If you do not understand them or have some concern about some not mentioned, please ask us. Operations on nerves are particularly difficult for the patient and surgeon. Complaints of pain can be frequently relieved with surgical treatment. In some cases, however, pain does not subside and may become worse even though the operation is well performed and no specific injury or accident occurs during the procedure. This is because of the particular sensitive nature of nerves and the fact that internal nerve scarring may have occurred as a result of nerve compression. This internal scarring cannot be relieved with external decompression in all cases. The patient should understand that operations involving nerves carry a specific risk for persistent pain and/or weakness despite appropriate surgical intervention. If this is of concern to you, please discuss this with your surgeon.

☐ The responsibility for your surgical anesthetic will be undertaken by an anesthesiologist. You are encouraged to discuss the benefits, alternatives and possible complications with the anesthesiologist prior to your operation.

☐ _____ (← fill in Dr.'s name) has and ownership interest in _____ (← fill in facility name). You may choose another facility for your operation. If this is a concern, please discuss this with your surgeon.

☐ Some Orthopaedic & Hand Surgery operations require the use of metal plates, screws, pins & joint implants. All materials that remain in your body will experience wear and mechanical strain. These materials, regardless of high standards of manufacturing, may break loose, loosen, wear out, or become infected. In some cases your surgeon will advise removing a device when its job is done. This is a routine consideration when using implantable materials. If you have a concern about implant failure or need for removal, please discuss this with your surgeon.

_____

Patient Statement of Comprehension (please print "I UNDERSTAND" on the line above)

_____

Patient Name (please PRINT on the line above)

_____ ***Date:*** _____

Patient Signature (please SIGN on the line above)