PIONEERS MEMORIAL HealthcareDistrict

PRE-ANESTHESIA QUESTIONNAIRE

Patient Name: _____

Record #: _____

Age _____ Weight _____ Height _____ Occupation _____

Have you donated blood for your surgery: Yes _____ No _____ If so, how many units? _____

Have friends or family donated blood for your surgery: Yes _____ No _____ If so, how many units? _____

Physical activity now: Little _____ Moderate _____ Active _____ Very Active _____

Can you climb stairs? Yes ____ No ____ Number of flights: 1 _____ 2 _____ 3+ _____

Do you have a cold? Yes ____ No ____

YES	NO	YEAR	HEART DISEASE
____	____	____	Heart Attack
____	____	____	Angina, Chest pain
____	____	____	Irregular heart beat
____	____	____	High blood pressure
____	____	____	Rheumatic fever
____	____	____	Heart murmur
____	____	____	Mitral valve prolapse
			NEUROLOGICAL DISEASE
____	____	____	Stroke, fainting spells
____	____	____	Sleep apnea/sleep disorders
____	____	____	Epilepsy, convulsions
____	____	____	Glaucoma
____	____	____	Mental illness
____	____	____	Parkinsonism
____	____	____	Migraine headaches
			ENDOCRINE DISEASE
____	____	____	Hypo/hyperthyroidism
____	____	____	Diabetes

YES	NO	YEAR	LUNG DISEASE
____	____	____	Asthma
____	____	____	Emphysema, Bronchitis
____	____	____	Tuberculosis
____	____	____	Pulmonary emboli
			GASTROINTESTINAL DISEASE
____	____	____	Ulcers
____	____	____	Hiatal hernia
____	____	____	Hepatitis
____	____	____	**KIDNEY DISEASES**
____	____	____	**MUSCLE DISEASES**
____	____	____	Myasthenia Gravis
____	____	____	Malignant Hyperthermia
			OTHER
____	____	____	Back pain or injury
____	____	____	Alcohol/drug addiction
____	____	____	Porphyria (AIP, VP, HC)
____	____	____	Other/not mentioned above, List Below
____	____	____	_____
____	____	____	_____
____	____	____	_____
____	____	____	_____
____	____	____	_____

____ ____ Are you allergic to any medications, adhesive tape or iodine? Please identify:

_____

_____

____ ____ Do you drink alcoholic drinks every day?

If so, how many? _____

____ ____ Do you smoke? If yes, how much? _____ How many years? _____

____ ____ Have you ever smoked? If yes, how much? _____ How many years? _____

When did you quit? _____

____ ____ If female, is there any possibility that you are pregnant at this time?

____ ____ Do you have dentures, bridges, caps, loose or chipped teeth? (Please circle)

____ ____ Do you wear contact lenses, false eyelashes or a false eye? (Please circle)

____ ____ Do you have difficulty opening your mouth?

____ ____ Do you have difficulty moving your neck?

WHAT OPERATIONS HAVE YOU HAD, AND APPROXIMATE YEAR? *(If none, so state please)*

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

(Please check) **WHAT KIND OF ANESTHESIA HAVE YOU HAD?**

____ General (Pentothal-Gas), ____ Saddle Block or Spinal, ____ Nerve Blocks, ____ Local Anesthesia

YES NO

____ ____ Have you or your immediate family had unusual reactions, problems or complications associated with anesthesia (e.g. hepatitis, jaundice, muscle weakness, breathing problems or unexplained fevers)?

PLEASE COMPLETE ALL OTHERS SIDES OF THIS FORM, THANK YOU

PLEASE CIRCLE OR WRITE IN CURRENT MEDICATIONS PLUS ANY TAKEN IN THE LAST 6 MONTHS

	DOSAGE	LAST TAKEN
Heart and Blood Pressure Medicines:		
Inderal, Lopressor, Corgard, Tenormin		
Nitroglycerin Patch/Oral, Isordil		
Procardia, Cardiazem, Verapamil		
Digitalis, Digoxin, Lanoxin, Procan		
Quinidine		
Dyazide, Hydrochlothiazide Lasix		
Clonidine, Catapres, Capoten, Apresoline		
Other (Please List)		
Lung (Asthma, Tuberculosis) Medicines:		
Inhalers (Please List)		
Pills		
Theodur, Slo-Bid		
Other (Please List)		
Steroids:		
Prednisone, Cortisone, ATCH		
Other (Please List)		
Pain and Arthritis Medicines:		
Aspirin		
Other (Please List)		
Blood Thinners (Anticoagulants):		
Coumadin, Persantin		
Other (Please List)		
Endocrine Medicines:		
Diabetic Pills - Dose and Type:		
Insulin (Type, dose, and time taken):		
Thyroid medicine		
Other (Please List)		
Ulcer, Hiatal Hernia Medicines:		
Tagamet, Zantac		
Other (Please List)		
Antidepressants and Epilepsy Medication:		
Lithium (Eskalith)		
Isocarboxazid (Marplan)		
Pargyline (Eutonyl)		
Phenelzine (Nardil)		
Tranylcypromine (Parnate)		
Dilantin, Phenobarb		
Other (Please List)		
Glaucoma Medications:		
Timoptic, Floropryl,		
Phospholine		
Other (Please List)		
OTHER MEDICATIONS:		
Please List		

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)