exer URGENT CARE™

PATIENT FIRST NAME: _____
PATIENT LAST NAME: _____
PATIENT DATE OF BIRTH MM/DD/YYYY: _____

Preoperative Patient Questionnaire

PATIENT DEMOGRAPHICS						
Patient Name	First		Last			
Date of Birth (Month/Day/Year)			Age		Gender	

PLANNED PROCEDURE INFORMATION				
Preoperative Diagnosis				
Planned Procedure				
Date of Procedure		Type of Anesthesia (okay to leave blank if unknown)		
Surgeon		Facility Address		
		City, State		
		Zip Code		
		Telephone	Fax	
		Email		

ALLERGIES/PRIOR ANESTHESIA PROBLEMS/SOCIAL HISTORY		
Are you allergic to latex? If yes describe reaction: _____	☐ Yes	☐ No
Do you have any allergies to any medication? name: _____ reaction: _____ name: _____ reaction: _____ name: _____ reaction: _____		☐ No
Do you have any allergies to food or other allergies? If Yes, list:		☐ No
Have you ever had anesthesia? ☐ General anesthetic ☐ Spinal or Epidural ☐ Nerve block ☐ Sedation (eg. Colonoscopy)		☐ No

Have you had any problems with anesthesia? ☐ Malignant Hyperthermia ☐ Nausea/vomiting ☐ Pseudocholinesterase deficiency ☐ Difficulty with insertion of the anesthesia breathing tube ('difficult intubation') ☐ Other If Yes: Describe: _____		☐ No
Do you have a blood relative who has had problems with anesthesia? ☐ Malignant Hyperthermia (high fever) ☐ Pseudocholinesterase deficiency ☐ Other		☐ No
Do you have any loose teeth? If yes, which teeth _____ Do you have dentures? ☐ partial upper ☐ full upper ☐ partial lower ☐ full lower Do you have: ☐ veneers ☐ caps ☐ crowns ☐ bridges If yes, which teeth _____		☐ No ☐ No ☐ No
Do you get motion sickness?	☐ Yes	☐ No
Do you smoke or have you ever smoked? If Yes: # of cigarettes a day: _____ # of years smoked: _____ Year stopped: _____		☐ No
Do you use recreational drugs, street drugs or marijuana/cannabis? If Yes: Type: _____ Amount: _____ How often: _____ Type: _____ Amount: _____ How often: _____		☐ No
Do you drink alcohol such as beer, wine and/or liquor? If Yes: # of drinks a week: _____	☐ Yes	☐ No
Could you be pregnant? Date of Last menstrual period _____	☐ Yes	☐ No

Medications and Supplements

Include prescription and non-prescription medication you take including inhalers, creams, patches, drops, vitamins, and herbal supplements. If you have your list of your medications from a pharmacist or primary care provider, you do not need to write these medications here. You can attach to this form.

Name	Dose	How often	Reason

Have you taken cortisone, prednisone, or other steroids for more than 10 days in the last 30 days?	☐ Yes	☐ No

Cardiovascular		
Have you ever had: ☐ high blood pressure ☐ heart attack ☐ heart murmur ☐ angina/chest pain ☐ heart failure ☐ irregular heart beat/arrhythmia ☐ heart valve problem ☐ peripheral vascular disease ☐ Other heart problems _____		☐ No
Do you have a Cardiologist? If Yes: Name: _____ Last visit: _____		☐ No
Do you have a: ☐ pacemaker ☐ defibrillator (ICD) ☐ stents ☐ artificial heart valve		☐ No
Have you needed: ☐ heart surgery ☐ carotid surgery ☐ surgery on major arteries or veins		☐ No
Have you had a: ☐ stress test ☐ angiogram/cardiac catheterization ☐ echocardiogram		☐ No
Have you ever used nitrates for angina/chest pain?	☐ Yes	☐ No
Respiratory		
Have you ever been diagnosed with: ☐ asthma ☐ tuberculosis ☐ emphysema ☐ COPD ☐ Pulmonary hypertension ☐ other breathing or lung problems _____		☐ No
Do you have a Pulmonologist? If Yes: Name: _____ Last Visit: _____		☐ No
Do you use oxygen at home? If Yes, how much? _____		☐ No
Do you have sleep apnea? If Yes, do you: ☐ use CPAP ☐ use BiPAP ☐ don't use CPAP		☐ No
Have you ever had a sleep study?	☐ Yes	☐ No
Gastrointestinal		
Have you ever had liver problems such as hepatitis or cirrhosis?	☐ Yes	☐ No
Do you have frequent heartburn (GERD), ulcer(s) or a hiatus hernia?	☐ Yes	☐ No
Do you have a Gastroenterologist? If Yes: Name: _____ Last Visit: _____	☐ Yes	☐ No
Renal		
Have you ever had kidney disease? Describe: _____	☐ Yes	☐ No
Are you a dialysis patient? ☐ peritoneal ☐ hemodialysis		☐ No
Do you have a Nephrologist? If Yes: Name: _____ Last Visit: _____		☐ No
Endocrine		
Do you have diabetes? ☐ Type 1 ☐ Type 2 ☐ Gestational How is your diabetes managed? ☐ diet ☐ oral medication ☐ insulin		☐ No
Do you have thyroid disease? If Yes: ☐ hyperthyroidism ☐ hypothyroidism		☐ No
Do you have an Endocrinologist? If Yes: Name: _____ Last Visit: _____		☐ No
Neurological/Rheumatological		
Have you ever had: ☐ Stroke (CVA) ☐ Mini-Stroke (TIA) ☐ Seizures If Yes: When was your last episode? _____		☐ No
Do you have: ☐ Multiple Sclerosis ☐ Parkinson's ☐ Alzheimer's ☐ memory problems ☐ Other neurologic or muscle disorders _____		☐ No
Do you get: ☐ numbness ☐ tingling or ☐ weakness of your arms (☐ L, ☐ R) or legs (☐ L, ☐ R)?		☐ No
Do you have a Neurologist? If Yes: Name: _____ Last Visit: _____		☐ No

Do you have autoimmune disease? If Yes: ☐ Lupus ☐ Rheumatoid arthritis ☐ Other: _____		☐ No
Do you have a Rheumatologist? If Yes: Name: _____ Last Visit: _____		☐ No
Hematological		
Have you ever been diagnosed with: ☐ bleeding disorder ☐ Anemia ☐ Sickle cell disease ☐ low blood iron ☐ Thalassemia ☐ low platelets ☐ other _____		☐ No
Have you ever had a blood clot in your ☐ legs or ☐ lungs? If yes, when? _____		☐ No
Have you ever taken any blood thinner medication? If Yes: Name: _____		☐ No
Do you bruise easily, get nosebleeds, or bleed excessively after brushing teeth?	☐ Yes	☐ No
Do you have a Hematologist? If Yes: Name: _____ Last Visit: _____	☐ Yes	☐ No
Oncology		
Have you ever been treated for cancer? If Yes: Type: _____ Year: _____		☐ No
Have you received *bleomycin* as chemotherapy?	☐ Yes	☐ No
Do you have an Oncologist? If Yes: Name: _____ Last Visit: _____		☐ No
Infectious Diseases		
Have you ever been diagnosed with ☐ HIV/AIDS ☐ Hepatitis B ☐ Hepatitis C ☐ MRSA or Staph infections		☐ No
Do you have an Infectious Disease Specialist? If Yes: Name: _____ Last Visit: _____		☐ No
Mental Health		
Have you ever been treated for: ☐ anxiety ☐ depression ☐ bipolar disease ☐ psychosis ☐ obsessive compulsive disorder ☐ PTSD ☐ schizophrenia ☐ substance use disorder ☐ other mental health problem: _____		☐ No
Do you have a Psychiatrist? If Yes: Name: _____ Last Visit: _____		☐ No
Are you currently being treated for any of the above mental health illnesses or addictions? Describe: _____	☐ Yes	☐ No
Surgical History Have you had any previous surgery?		☐ No

Surgery	**Year**		

Do you have any other medical conditions or specific questions or concerns that you would like to discuss?	☐ Yes	☐ No
Please describe:		
Have you had any of the following recently?		
Have you had a cold, flu, or chest infection in the last month?	☐ Yes	☐ No
Do you have a cough with sputum?	☐ Yes	☐ No
Do you have any problems with your breathing? Describe:	☐ Yes	☐ No
Burning or Urgency with Urination?	☐ Yes	☐ No
Chest pain or shortness of breath with activity?	☐ Yes	☐ No
Activity Status Questionnaire Can you:		
1. Take care of yourself, that is eating, dressing, bathing, or using the toilet?	☐ Yes	☐ No
2. Walk indoors, such as around the house?	☐ Yes	☐ No
3. Walk a block or 2 on level ground?	☐ Yes	☐ No
4. Climb a flight of stairs or walk up a hill?	☐ Yes	☐ No
5. Run a short distance?	☐ Yes	☐ No
6. Do light work around the house like dusting or washing dishes?	☐ Yes	☐ No
7. Do moderate work around the house like vacuuming, sweeping floors or carrying groceries?	☐ Yes	☐ No
8. Do heavy work around the house like scrubbing floors, or lifting or moving heavy furniture?	☐ Yes	☐ No
9. Do yardwork like raking leaves, weeding, or pushing a power mower?	☐ Yes	☐ No
10. Have sexual relations?	☐ Yes	☐ No
11. Participate in moderate recreational activities like golf, bowling, dancing, doubles tennis, or throwing a baseball or football?	☐ Yes	☐ No
12. Participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing?	☐ Yes	☐ No

Patient Attestation: I attest to the best of my knowledge that the information on this form is accurate and true.

Name of Person Completing Form		Relationship to Patient	
Signature of Person Completing Form		Date	