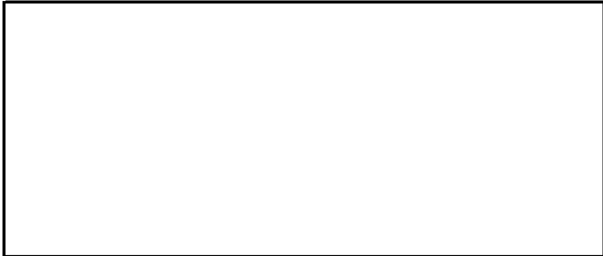
Peri-Operative

Health Screening Form

North Country Orthopaedic Ambulatory Surgery Center

Watertown, New York



Please answer all questions about your (the patient's) health. Answer "YES" or "NO" or "UNSURE". If you answer "YES" to a particular question, please mark any of the options listed below the question that applies to you.

Patient Name:			Phone (H):		(Alt:)	
Date of Birth:	Age:	Sex: M / F	Ht: Ft. In	Wt: Lbs	County:	
Patient Street Address:			City:		State:	Zip Code:
Race: (Please Circle): White, Asian, African American,			Alaskan Native, Other [Optional - Demographic Info Only]			

Emergency Contact: ______________________ **Relationship:**__________ **Phone:** __________

Name of person who will be taking you home: ______________________

Email address:______________________

1. Do you have any ALLERGIES to medicines or to latex rubber? ☐ **NO** ☐ **YES** ☐ **UNSURE**

1) .... 4) ....
2) .... 5) ....
3) .... 6) ....

2. Do you take PRESCRIPTION MEDICINES? ☐ **NO** ☐ **YES** ☐ **UNSURE**
Please list names & dose if known (You may attach a list) ☐ List Attached

1) .... 5) .... 9) ....
2) .... 6) .... 10) ....
3) .... 7) .... 11) ....
4) .... 8) .... 12) ....

3. Do you take OVER-THE-COUNTER or HERBAL MEDICINES? ☐ **NO** ☐ **YES** ☐ **UNSURE**
Please list names & dose if known (You may attach a list) ☐ List Attached

1) .... 3) ....
2) .... 4) ....

4. Have you ever had SURGERY? ☐ **NO** ☐ **YES** ☐ **UNSURE**
Please list SURGERY & date if known (You may attach a list) ☐ List Attached

1) .... 4) ....
2) .... 5) ....
3) .... 6) ....

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4a. Do you have any SURGICAL implants (Plates, Screws, Prosthesis)? ☐ **NO** ☐ **YES** ☐ **UNSURE**

Type of Implant:.. Location of Implant:.......................................

5. Do you have a NEUROLOGIC (BRAIN, NERVE, or MUSCLE) condition? ☐ **NO** ☐ **YES** ☐ **UNSURE**

☐ Stroke or TIA (mini-stroke) ☐ Headaches ☐ Multiple sclerosis ☐ Parkinson's Disease
☐ Dementia ☐ Head Trauma ☐ Paralysis ☐ Seizures
☐ Other: ....

6. Have you ever had a HEART condition? ☐ **NO** ☐ **YES** ☐ **UNSURE**

☐ Angina or Chest Pain ☐ Heart Murmur ☐ Thrombophlebitis/Blood Clot
☐ Congenital/Born with Heart Problem ☐ High Cholesterol ☐ Valvular Heart Disease
☐ Congestive Heart Failure ☐ High Blood Pressure ☐ Abnormal EKG
☐ Coronary Heart Disease ☐ Irregular Heart Beat ☐ Cardiac Cath Date(s).............................
☐ Endocarditis ☐ Palpitations ☐ Pacemaker
☐ Heart Attack Date(s)................................. ☐ Rheumatic Fever ☐ AICD (Automatic Defibrillator)
☐ Other Heart Condition or Procedure (Describe) ....
☐ Who is your Heart Doctor? ....

7. Have you had BREATHING problems or a LUNG condition? ☐ **NO** ☐ **YES** ☐ **UNSURE**

☐ Asthma ☐ Short of Breath when lying down flat ☐ Blood Clot in Lungs
☐ Bronchitis or Chronic Cough ☐ Coughing up Blood ☐ Recent Cold or Flu (Last 2 Weeks)
☐ Emphysema or COPD ☐ Lung Cancer ☐ Tuberculosis
☐ Cystic Fibrosis ☐ Pneumonia Date(s) .... ☐ Use Oxygen at Home
☐ Other BREATHING or LUNG conditions (Describe)..

8. Do you think that you have SLEEP APNEA? (Discuss with Sleep Partner) ☐ **NO** ☐ **YES** ☐ **UNSURE**

☐ Have breathing pauses during sleep ☐ Snore Loudly ☐ Been treated for sleep disorder
☐ Fight to stay awake during day ☐ Tested for sleep apnea ☐ Use C-PAP / Setting: ....

9. Do you have an ORAL, DIGESTIVE or WEIGHT problem? ☐ **NO** ☐ **YES** ☐ **UNSURE**

☐ Dentures or Partial Plates ☐ Cirrhosis ☐ Hiatal Hernia ☐ Food Intolerance
☐ Chipped or loose teeth ☐ Hepatitis ☐ Acid Reflux or Heartburn ☐ Severe Weight Loss
☐ Eating Disorder ☐ Stomach Ulcers ☐ Rectal Bleeding ☐ Take Diet Pills
☐ Other Digestive Disorders: ....

10. Do you have a LIVER, KIDNEY, OR PROSTATE condition? ☐ **NO** ☐ **YES** ☐ **UNSURE**

☐ Renal (Kidney) Failure ☐ Peritoneal Dialysis ☐ Prostate Cancer
☐ Hemodialysis ☐ Urinary Tract Infection/Past 4 Weeks ☐ Enlarged Prostate
☐ Other (Describe): ....

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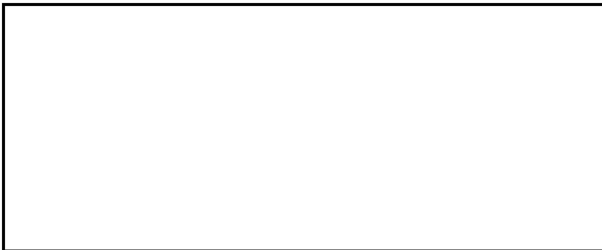

11. Is there any chance that you are now PREGNANT? ☐ NO ☐ YES ☐ UNSURE

Please provide the date of your last menstrual period _______ Month _____Day _____ Year

12. Do you have an Eye, Ear, Nose, or Throat condition? ☐ NO ☐ YES ☐ UNSURE

☐ Cataracts ☐ Frequent Nose Bleeds ☐ Hoarseness
☐ Cleft Lip or Palate ☐ Hearing Loss ☐ Bleeding From Mouth
☐ Other (Describe): ....

13. Do you have an ENDOCRINE (DIABETES, or THYROID) condition? ☐ NO ☐ YES ☐ UNSURE

☐ Diabetes ☐ Oral Medication (Pills) for Diabetes ☐ Hypothyroid (Underactive)
☐ Diabetes controlled by Diet Only ☐ Insulin for Diabetes ☐ Hyperthyroid (Overactive)
☐ Other: ....

14. Do you have MUSCLE or JOINT problems? ☐ NO ☐ YES ☐ UNSURE

☐ Rheumatoid arthritis ☐ TMJ (Jaw Joint Problems) ☐ Upper back problem ☐ Muscle Weakness
☐ Osteoarthritis ☐ Low Back Problem ☐ Cervical (neck) problem ☐ Myasthenia Gravis
☐ Other: ....

15. Do you have a BLOOD or BLEEDING disorders? ☐ NO ☐ YES ☐ UNSURE

☐ Anemia ☐ Abnormal Bleeding ☐ Bruise Easily ☐ Thrombophlebitis
☐ Sickle Cell Disease ☐ Other: ....

16. Do you have any Psychological or Social Conditions? ☐ NO ☐ YES ☐ UNSURE

☐ Anxiety ☐ Behavior Problems ☐ Claustrophobia ☐ Depression
☐ Other: ....

17. Do you have difficulty breathing and/or chest pressure with… ☐ NO ☐ YES ☐ UNSURE

☐ Climbing a flight of stairs ☐ Daily activities (Bathing, cooking, shopping) ☐ Running a short distance
☐ Climbing two (2) flights of stairs ☐ Heavy house work (scrubbing floors, lifting, or moving furniture)

18. Describe any regular Physical Exercise that you do:

....

19. Have you had CANCER? ☐ NO ☐ YES ☐ UNSURE

☐ Type of Cancer ☐ Chemotherapy-Date(s) .... ☐ Radiation - Date ....

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20. Do you have any other medical conditions not listed? ☐ **NO** ☐ **YES** ☐ **UNSURE**

....

....

....

21. Do you have any concerns about your ANESTHESIA or SURGERY? ☐ **NO** ☐ **YES** ☐ **UNSURE**

....

....

22. Have you SEEN a DOCTOR in last 6 months? ☐ **NO** ☐ **YES** ☐ **UNSURE**

Primary Care Physician Name .... Other Physician Name ....

Last Visit on: .... To See On: .... Last Visit on: .... To See On: ....

23. Have you had any MEDICAL TESTS in last 6 months? ☐ **NO** ☐ **YES** ☐ **UNSURE**

	☐ Blood Tests	☐ EKG	☐ Chest X-Ray	☐ Stress Test
Date of Test:	....	....	....	....
Place of Test:	....	....	....	....

☐ Other (describe): ....

24. Have you ever smoked? Do you drink ALCOHOL or use DRUGS? ☐ **NO** ☐ **YES** ☐ **UNSURE**
Recent Cocaine or Amphetamine use can cause sudden death during anesthesia!

☐ Cigarette Smoking	___ Packs / Day	___Years of smoking	☐ Other
☐ Alcohol	___ Drinks per Week	___Years of drinking	
☐ Cocaine	☐ Heroin	☐ Marijuana	

25 Have you ever had a problem related to alcohol? ☐ **NO** ☐ **YES** ☐ **UNSURE**

26. Any previous DIFFICULTIES or COMPLICATIONS with Anesthesia? ☐ **NO** ☐ **YES** ☐ **UNSURE**

☐ Difficult Intubation (breathing tube insertion)
☐ Difficulty waking up
☐ Severe Nausea or Vomiting
☐ Awareness (remembered being in surgery)
☐ Malignant Hyperthermia
☐ Family member had major anesthesia problem
☐ Other (describe) ....

27. Do you have a HEALTH CARE PROXY? (If so, bring with you) ☐ **NO** ☐ **YES** ☐ **UNSURE**
28. Do you have any special needs upon discharge after your surgery? ☐ **NO** ☐ **YES** ☐ **UNSURE**
29. Children 0-18 years: Are immunizations up-to-date? ☐ **NO** ☐ **YES** ☐ **UNSURE**
Please provide a copy day of surgery.

Signature of Person Completing Form: ________________________ **Date:** ________________________