Pre-Operative Assessment

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| Patient Name | | |  | Age |  | | Sex | |  | Date | |
| **For the Following Questions, Please Indicate “Yes” “No” or “Do Not Know”.** *Please answer all of the questions.* | | | | | | | | | | | |
| 1. Do you currently take any of the following medications? | a) Aspirin (excedrin, anacin, bufferin) | | | | | Yes | | No | | | Do Not Know |
| b) Anticoagulants (blood-thinning medicine) | | | | | Yes | | No | | | Do Not Know |
| c) Propanol, Verapamil (heart rhythm medicines) | | | | | Yes | | No | | | Do Not Know |
| d) Diuretics (water pills) | | | | | Yes | | No | | | Do Not Know |
| e) Antihypertensive drugs (blood pressure pills) | | | | | Yes | | No | | | Do Not Know |
| f) Digitalis (heart pills) | | | | | Yes | | No | | | Do Not Know |
| g) Stereoids (prednisone, cortisone) | | | | | Yes | | No | | | Do Not Know |
| 1. Have you ever been treated for cancer with chemotherapy or radiation therapy?   If yes: when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Yes | | No | | | Do Not Know |
| 3. Do you currently have any problems with your: | a) Liver (e.g. cirrhosis, hepatitis, yellow jaundice) | | | | | Yes | | No | | | Do Not Know |
| b) Kidneys (infection, stones, failure) | | | | | Yes | | No | | | Do Not Know |
| c) Spleen | | | | | Yes | | No | | | Do Not Know |
| d) Blood (anemia, leukemia) | | | | | Yes | | No | | | Do Not Know |
| 4. Have you or anyone in your family ever had a serious bleeding problem? | | | | | | Yes | | No | | | Do Not Know |
| 5. Have you ever had prolonged or unusual bleeding from tooth extractions, cut, surgery or nosebleed? | | | | | | Yes | | No | | | Do Not Know |
| 6. Do your gums bleed when you brush your teeth? | | | | | | Yes | | No | | | Do Not Know |
| 7. Are you pregnant? | | | | | | Yes | | No | | | Do Not Know |
| 8. Is there any possibility that you are pregnant? | | | | | | Yes | | No | | | Do Not Know |
| 9. Have been told you have diabetes? | | | | | | Yes | | No | | | Do Not Know |
| 10. Do you wake up to urinate more than once at night? | | | | | | Yes | | No | | | Do Not Know |
| 11. Do you have muscle cramps or pains? | | | | | | Yes | | No | | | Do Not Know |
| 12. Do you have problems with your lungs or chest? (e.g., chest pain, skipped heart beats, high blood pressure, smoke one or more packs a day, shortness of breath, emphysema, asthma, bronchitis) underline all that apply | | | | | | Yes | | No | | | Do Not Know |
| 13. Do you have a cough, or cough frequently? | | | | | | Yes | | No | | | Do Not Know |
| 14. Do you have epilepsy or suffer from fits or seizures? | | | | | | Yes | | No | | | Do Not Know |
| 15. Do you have neck or back problems? | | | | | | Yes | | No | | | Do Not Know |
| 16. Are you scheduled to have an operation? | | | | | | Yes | | No | | | Do Not Know |
| If Yes, what operation? | |  | | | | | | | | | |
| 17. Are you currently taking any medications? | | | | | | Yes | | No | | | Do Not Know |
| If Yes, please list: | |  | | | | | | | | | |