BEND SURGERY CENTER
In for Care • Home for Comfort

1303 NE Cushing Drive, Suite 200
Bend, Oregon 97701
Phone (541) 318-0858
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PRE-OPERATIVE QUESTIONNAIRE & EVALUATION

DATE OF PROCEDURE _____

PATIENT NAME _____ DOB _____ SURGEON _____

PROCEDURE _____ PRIMARY CARE DR. _____

PHONE (home) _____ (cell) _____ (work) _____ (EMAIL ADDRESS) _____

HEIGHT _____ WEIGHT _____ BMI _____ EMERGENCY CONTACT _____ PHONE _____

PERSON DRIVING YOU HOME _____ PHONE _____

BEND SURGERY CENTER MAY SPEAK TO THIS PERSON ABOUT MY HEALTH HISTORY (person's name) _____

MAY WE LEAVE A MESSAGE ON YOUR VOICEMAIL REGARDING YOUR MEDICAL PROCEDURE? ❑ YES ❑ NO (person's name) _____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE ❑ YES ❑ NO (Please bring a copy)

DO YOU HAVE A <u>SIGNIFICANT</u> HISTORY OR CURRENTLY HAVE: Please check Yes or No for both columns and circle what applies.

	YES	NO	
Neuro	❑	❑	Seizures / Last One _____
	❑	❑	Strokes, TIAs - R / L side affected / Explain _____
	❑	❑	Black out spells / Explain _____
	❑	❑	Numbness, weakness or paralysis / Explain _____
Heart	❑	❑	Heart attack, Cardiac Bypass _____ vessels / when _____
	❑	❑	Cardiac Stent _____ when _____
	❑	❑	Chest pains (angina) / Last episode _____
	❑	❑	Heart failure / Congestive heart failure / When? _____
	❑	❑	Irregular heart beat ❑ pacemaker ❑ Cardio-defibrillator (bring implant card) Explain _____
	❑	❑	Heart murmur, leaky valve - mitral / aortic, no symptoms
	❑	❑	Cardiologist? Name _____
	❑	❑	High blood pressure / medication(s) ❑ YES ❑ NO
Lung	❑	❑	Shortness of breath ❑ at rest ❑ with exercise only
	❑	❑	Asthma or wheezing, Emphysema, COPD, Explain _____
	❑	❑	Home Oxygen used @ _____ L, _____ hours per day
	❑	❑	TB or Recent cold or other lung issues _____
	❑	❑	Open wounds, sores, rashes, infections or MRSA? When _____
Abdomen	❑	❑	Heartburn, Acid Reflux, Ulcer disease or Hiatal Hernia
	❑	❑	Hepatitis - Type A, B, or C / When _____
	❑	❑	Kidney, Prostate or urination problems _____

	YES	NO	
Misc.	❑	❑	Diabetes: Type I / Type II / Since? _____
	❑	❑	Thyroid or other gland problems _____
	❑	❑	Anemia, bleeding or blood clots, DVT, PE _____
	❑	❑	HIV disease
	❑	❑	History of Cancer _____
	❑	❑	Arthritis, limited movement of joints _____
	❑	❑	Joint replacement R / L _____
	❑	❑	Muscle Disease / Family history of muscle disease _____
Anesthesia	❑	❑	Problems with any prior anesthesia? Nausea / vomiting / trouble waking up
	❑	❑	Do you have airway problems? Sleep apnea / CPAP / Oxygen ❑ Yes ❑ No
	❑	❑	Have you been told you have a difficult airway during surgery?
	❑	❑	Limited mouth opening or limited neck movement
	❑	❑	Blood relatives with life threatening anesthesia problems
	❑	❑	Motion sickness, anxiety attacks or claustrophobia
	❑	❑	Dental plates ☐ ☐ partial / permanent / loose teeth / chipped
	❑	❑	**Other** medical problems or comments _____

Were you admitted to the Emergency Dept./Urgent Care in the last year? ❑ YES ❑ NO Explain: _____

Do you **smoke or chew tobacco?** ❑ YES ❑ NO #_____ years smoked or chewed #_____ packs/cans per day (If you are a former smoker, what year did you quit?_____)

Do you **drink** alcohol? ❑ YES ❑ NO # drinks _____ per day # of drinks _____ per week Use recreational drugs? ❑ YES ❑ NO _____

Do you use Marijuana? ❑ YES ❑ NO Frequency? _____ ❑ Do not use Marijuana 8 hours prior to your procedure.

Do you have ❑ glasses, ❑ contacts, ❑ hearing aid(s), ❑ prosthetic? ❑ None _____

Do you have any implanted metal in your body? ❑ YES ❑ NO (Where?) _____

Do you have any mobility impairments? ❑ YES ❑ NO Do you use a: ❑ Cane ❑ Crutches ❑ Walker ❑ Wheelchair ❑ Paraplegic / Quadriplegic, Can you self-transfer ❑ YES ❑ NO

Do you have any **cultural / religious beliefs** that may affect our providing health care? ❑ YES ❑ NO / Explain _____

FEMALES: ❑ Menopause for over 2 years ❑ Hysterectomy Are you pregnant or could you be pregnant? ❑ Yes ❑ No, willing to sign a waiver ❑ Need a blood test

Please list your previous operations _____

History information obtained from ❑ Patient / family ❑ Interpreter/Name _____ ❑ Copied & verified with Patient / Representative _____

Please do not wear perfume, heavily scented lotions / oils.

<u>YOU ARE REQUIRED TO HAVE SOMEONE CARE FOR YOU THE FIRST 24 HOURS AFTER YOUR PROCEDURE OR YOU CAN NOT HAVE SURGERY.</u>

Patient Signature _____ Date _____

(Relationship if not patient _____)

X _____ R.N. _____ _____
(Nurse's Signature) (Date) (Time)

PATIENT LABEL HERE