Pre-Admission Testing Questionnaire

Approximately 2 weeks prior to your surgery date you will receive a telephone call from our Pre-Admission Testing department. During this conversation, a Registered Nurse will attempt to collect medically pertinent information that will assist us in delivering comprehensive, high-quality care to you throughout your surgical process. Please be prepared to provide the following information at the time of this telephone call:

GENERAL
What is the name of your current primary care physician (PCP)?_____________________
What is your planned procedure (for verification purposes)?_________________________
What is your current height and weight?________________________________________

ALLERGIES
Do you have any known allergies? YES NO
If “YES”, please list:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

• Eggs/ Soybeans? YES NO Which?____________
• Latex (rubber, condoms, balloons) YES NO

Are you allergic to any medications? YES NO
If “YES”, please list:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
MEDICATIONS
Are you taking any medications? **YES NO**
If “**YES**”, please provide name, dosage, frequency, and date last taken:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Do you take aspirin? **YES NO** Date last taken?____________
Do you take any herbal supplements? **YES NO**
If “**YES**”, please provide name, dosage, frequency, and date last taken:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

TOBACCO / ALCOHOL / ILLICIT and CONTROLLED SUBSTANCES
Do you use tobacco products? **YES NO**
If “**YES**”, please describe the type, how frequently used, and number of years:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
If you used tobacco products in the past, when did you quit?________________________

Do you consume alcohol? **YES NO**
If “**YES**”, how many drinks per week?__________________________________________
Do you use any illicit substances? **YES NO**  
*If “YES”, please provide name, frequency of use, and date last taken:*
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Is there a history of substance abuse? **YES NO**  
*If “YES”, please provide name, frequency of use, and date last taken:*
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Do you take medication for pain? **YES NO**  
*If “YES”, please provide name, frequency of use, and date last taken:*
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**SURGERIES / ANESTHESIA / HOSPITALIZATIONS**  
Please list ALL surgeries you have undergone in the past:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Have you ever experienced problems associated with anesthesia? **YES NO**  
*If “YES”, please describe:*
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Have any of your family members ever experienced problems associated with anesthesia?  
YES  NO  
If “YES”, please describe:  
_________________________________________________________________________  
_________________________________________________________________________  
_________________________________________________________________________  

Please list any previous hospital admissions for illness, other than surgery:  
_________________________________________________________________________  
_________________________________________________________________________  
_________________________________________________________________________  
_________________________________________________________________________  

OTHER IMPORTANT INFORMATION:  

Do you have any loose or chipped teeth? YES  NO  
If “YES”, please describe:  
_________________________________________________________________________  

Do you wear dentures? YES  NO  
If “YES”, please inform us of type (Upper / Lower / both)  

Do you have caps, crowns, or implants? YES  NO  
If “YES”, please describe:  
_________________________________________________________________________  

Do you wear contact lenses? YES  NO
DO YOU HAVE, OR HAVE YOU EVER EXPERIENCED, ANY OF THE FOLLOWING CONDITIONS?
HEENT (Head, Eyes, Ears, Nose, and Throat)
Motion Sickness
Vertigo or dizziness

CARDIAC
High blood pressure
High cholesterol
Chest pain (angina)
Palpitations
Heart attack (MI)
Congestive heart failure
Heart murmur, or mitral valve prolapsed
Rheumatic Fever
Cardiac catheterization
Stress test
Pacemaker

RESPIRATORY
Asthma
Bronchitis
Emphysema
Pneumonia
COPD
Recent test, or treated, for tuberculosis
Recent sore throat or chest cold
Sleep apnea
Shortness of breath when sleeping on 2 or more pillows
HEMATOLOGIC
Treated for anemia
Sickle cell anemia
Bruise easily
Have you ever received a
blood transfusion

ENDOCRINE
Thyroid disease
Diabetes If yes, for how long?

VASCULAR
Calf cramps during short walks
Phlebitis/ Embolism

GENITOURINARY
Renal failure
Kidney stones
Bladder infection
Polycystic kidney disease
Enlarged, or other issues related to the prostate

GASTROINTESTINAL
Ulcer, GERD
Hiatal hernia
Liver disease, or hepatits
Recent weight gain or loss
Colitis, or other issues related to the bowel
NEUROLOGIC
Seizures/epilepsy
Stroke or temporary blackout
Headaches (If so, please include type)
Sensory changes

MUSCULOSKELETAL
Rheumatoid or osteoarthritis
Arthritis of jaw, neck, or back
Difficulty opening mouth
Paralysis

PSYCHIATRIC: Psychiatric illness, or anxiety

FEMALES
Could you be pregnant?
Are you taking birth control pills?
What was the date of the first day of your last menstrual period? _____________

PEDIATRIC PATIENTS ONLY
Was the child born prematurely?
Within the past month, has the child had a cold, fever, or sore throat?
YES    NO

INFECTIOUS DISEASE
To your knowledge, have you been exposed to, or have you experienced, any recent acute infection of a communicable disease?
Influenza
Tuberculosis?
MRSA (Methicillin-Resistant Staphylococcus aureus)?
VRE (Vancomycin-Resistant Enterococci)?
C. diff (Clostridium difficile)?

YES    NO    Date

Tetanus-diphtheria
(Td)
Pneumococcal
Meningococcal
Influenza
Swine flu
Measles, mumps
rubella (MMR)
Varicella

If you are unsure about whether your medical history includes any of the above conditions, check with your primary care provider BEFORE you receive the Pre-Admission Testing telephone call interview. You may also bring this questionnaire to your primary care practitioner at the time of your pre-operative physical appointment to assist you in obtaining any unknown information.