Directions: Please fill out this form to the best of your ability. Today's Date: ___/___/___ Date of Surgery ___/___/___

Name _____ ☐ M ☐ F Age _____ Height _____ Weight _____

Surgeon _____ Primary Doctor _____

Reason for Admission _____

Who will be giving you a ride home/caring for you after surgery? _____

Primary Language English / Spanish / Other _____ Interpreter needed: Y / N

List previous surgeries / hospitalizations:

_____

_____

_____

_____

_____

_____

_____

Have you ever had? (circle all that apply)	YES	NO
1. Surgery requiring anesthesia_____	☐	☐
2. Any complications with anesthesia experienced by yourself or any blood relative_____	☐	☐
Severe nausea/vomiting post-op?_____	☐	☐
3. Chest pain/shortness of breath/murmurs/MI/ heart disease/pacemaker/defibrillator/palpitations	☐	☐
4. Pneumonia / TB / asthma / emphysema chronic cough / sleep apnea_____	☐	☐
5. Diabetes (sugar in blood) (insulin/oral meds/ diet controlled)_____	☐	☐
6. High blood pressure _____	☐	☐
7. Jaundice / liver disease / hepatitis _____	☐	☐
8. Stroke / seizure disorders / fainting spells_____	☐	☐
9. Blood disorders / anemia _____	☐	☐
10. Blood or plasma transfusions _____	☐	☐
11. Kidney disorders / kidney stones _____	☐	☐
12. GI problems / heartburn / reflux / ulcers / bleeding	☐	☐
13. Back pain or injury _____	☐	☐
14. Cancer _____	☐	☐
15. Thyroid disorder (hypo/hyper) _____	☐	☐

Pediatric Assessment (for patients under 12 years of age)

1. Full Term Premature
2. Delivery Vaginal C-section
3. Immunizations up to Date? ☐ Y ☐ N
4. Any problems since birth? ☐ Y ☐ N

Explain _____

Other medical problems / major illnesses / recent infections

_____

_____

_____

_____

_____

Comments

_____

_____

_____

_____

1. Do you presently have? (circle all that apply)
   Contact Lenses / Glasses Hearing Aid
   Dental Appliances: Removable Permanent

	YES	NO	Explain
2. Do you drink alcohol?	☐	☐	_____ /week
Do you smoke tobacco?	☐	☐	_____ /day
Smokeless tobacco?	☐	☐	_____
Other recreational drugs?	☐	☐	_____
3. Would you accept blood in an emergency?	☐	☐	_____
Has blood been donated for surgery?	☐	☐	_____
4. If female, could you be pregnant?	☐	☐	_____
5. Any religious or cultural beliefs that might affect your care?	☐	☐	_____
6. Challenges with Speech / Vision / Hearing / Mobility / Transportation	☐	☐	_____

List current meds (include route and dose) and allergies below:

If planned observation/inpatient, document on 'Home Medications' form

☐ See Home Medications form for medications & allergies

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any allergies or sensitivities to the following:

Explain reaction (i.e. rash, hives, nausea, etc.)

☐ NO KNOWN ALLERGIES

☐ Penicillin	_____
☐ Codeine	_____
☐ Demerol	_____
☐ Intravenous iodine or x-ray dye	_____
☐ Latex (Airborne or Contact)	_____
☐ FOOD ALLERGIES	
☐ Sulfa	_____
☐ Morphine	_____
☐ Aspirin	_____
☐ Other _____	_____
☐ Other _____	_____

Patient Signature _____ Nurse Signature _____

Pre-Op Patient Assessment Questionnaire

W-1161 (0905)

THE HOSPITAL AT WESTLAKE MEDICAL CENTER

ACCT# «PatientNumber» DOB:«BirthDate»
«Gender» «Age»
«PatientName» «AdmitDate»
«AdmittingDoctorName» MR#«MedicalRecordNumber»