BARNES JEWISH Hospital
BJC HealthCare

Washington University in St. Louis
SCHOOL OF MEDICINE

CENTER FOR PRE-OPERATIVE ASSESSMENT AND PLANNING HEALTH QUESTIONNAIRE OUTPATIENT

PATIENT IDENTIFICATION

Please check (✓) the appropriate box (☐) and fill in the blank(s) as needed.

Name:	Sex: ☐ Male ☐ Female	Date of Birth:
Home Phone #:	Daytime/Cell #:	Age:
Primary Care Doctor (Family Physician) Name/Phone #:	Cardiologist Name/Phone #:	

Allergies/Sensitivities: ☐ No Known Allergies ☐ Latex ☐ Betadine ☐ Tape/Band-Aids ☐ Lidocaine
Other:

Please list any previous operations:

Operation	Year	Operation	Year

Are you currently pregnant or lactating?
☐ No
☐ Yes

Have you been pregnant in the last 90 days?
☐ No
☐ Yes

When was your last menstrual period? _____

Have you had a blood transfusion in the last 90 days?
☐ No
☐ Yes – Date: _____

Have you had any problems with anesthesia?
☐ No
☐ Yes

Has any member of your family had problems with anesthesia?
☐ No
☐ Yes

Are you taking any blood thinners like Lovenox, Heparin, Coumadin or Plavix?
☐ No
☐ Yes

Are you a Jehovah's Witness: ☐ Yes ☐ No

Do you have questions for the anesthesiologist?
☐ No
☐ Yes

Who will be the responsible adult providing care for the 24 hours after discharge:

_____

Person completing form:

_____

_____
(Please print name and relationship to patient)

Signature: _____ **Date:** _____

Time: _____

DO NOT WRITE BELOW THIS LINE

BJ 7-3343-2010

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Please check (✓) the appropriate box (☐) and fill in the blank(s) as needed.

1. Do you have any of the following?

- ☐ Visual impairments (blind)
- ☐ Hearing impairments (deaf)
- ☐ Physical disabilities (use assisting devices as)
  - ☐ Wheelchair
  - ☐ Cane
  - ☐ Walker

2. Have you had any of the following heart related conditions?

YES	NO	
☐	☐	Heart attack, date: _____
☐	☐	Chest pain at rest or during activity
☐	☐	Heart failure
☐	☐	Shortness of breath when you lie flat
☐	☐	Pacemaker/ICD
☐	☐	Heart stents
☐	☐	Heart surgery
☐	☐	Medically treated irregular heart beat
☐	☐	Coronary artery disease
☐	☐	Heart valve disease
☐	☐	Heart murmur

Have you ever been on isolation for an infection where visitors wore gowns, masks?

Where: _____

When: _____

3. Do you have or have you had:

Now	Previously	Never	
☐	☐	☐	Cervical spine injury/disease
☐	☐	☐	High blood pressure
☐	☐	☐	Migraine
☐	☐	☐	Home oxygen therapy
☐	☐	☐	Tracheotomy
☐	☐	☐	Emphysema
☐	☐	☐	Asthma
☐	☐	☐	Stroke – date: _____
☐	☐	☐	Seizures/epilepsy
☐	☐	☐	Kidney disease
☐	☐	☐	Hepatitis
☐	☐	☐	Jaundice
☐	☐	☐	Liver disease
☐	☐	☐	Hiatal hernia
☐	☐	☐	Reflux
☐	☐	☐	Severe heartburn
☐	☐	☐	Bleeding problems
☐	☐	☐	Diabetes
☐	☐	☐	Steroid use
☐	☐	☐	Sleep apnea
☐	☐	☐	Blood clots – date: _____
☐	☐	☐	Arthritis – type: _____
☐	☐	☐	Lupus
☐	☐	☐	Anemia
☐	☐	☐	Cancer – type: _____
☐	☐	☐	Neuromuscular disorders
☐	☐	☐	HIV
☐	☐	☐	Other: _____

DO NOT WRITE BELOW THIS LINE