

## WELCOME TO PRE-OPERATIVE SERVICES

Our goal is to ensure that you are appropriately prepared for your upcoming surgery. Your visit with us today can take up to 2 hours, depending on the number of interviews and tests you need. Please take a moment to fill in the following questionnaire:

Name Date Surgeon Surgery Date Height: Weight: 1. Age: 2. Circle correct answer: my surgery is on my LEFT / RIGHT / both / I don't know / Not applicable 3. Primary Care Physician: Name: \_\_\_\_\_ Phone: \_\_\_\_ Fax: \_\_\_\_ Town/State: \_\_\_\_ In case we need to get information from them, please list other physicians you see: Specialty Name Phone Fax Specialty Phone Fax Name Phone Specialty Name Fax Were you asked to see any of these physicians prior to surgery? No Dr 4. Have you ever had (If Yes, when and where?) any of the following tests? EKG \_\_\_\_\_ STRESS TEST \_\_\_\_ ECHO 5. In the last 6 months, have you had a) blood work? Yes No b) Chest X-ray? Yes No 6. Have you ever had a) post-operative nausea and vomiting? Yes No b) Motion Sickness? Yes No 7. Please list all major illnesses: 8. Are you out of breath after climbing one flight of stairs? Yes 9. Have you ever been diagnosed with any of the following? (Insulin: Yes No) No Blood Clot (Deep Vein Thrombosis) Yes No Yes Reflux/Heartburn No Sleep apnea Yes No Sleep study: date: If yes, do you use CPAP? Y/N Dental appliance? Y/N Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? Yes No Do you often feel tired, fatigued, or sleepy during daytime? Yes No Has anyone observed you stop breathing during your sleep? Yes No Do you have or are you being treated for high blood pressure? Yes No If you answered yes to 2 or more of the above questions in this box- you may have obstructive sleep apnea and should consult with

## Please turn over and complete both sides.

your primary care physician about a sleep clinic referral

10 List	ALLER	GIES	and type	of reactions:
TO, LIST	ALLER	CULLY	and type	or reactions.

Medication/Food	Reaction	Medication/Food	Reaction

Do you have a Latex allergy? Yes No

11. PLEASE LIST <u>ALL</u> MEDICATIONS you are presently taking or attach a copy of your med list (include vitamins, herbal and over the counter medications.)

Medication	<u>Dose</u>	<u>Frequency</u>	<u>Indication</u>
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2. Do you use buprenorphine, suboxone, butrans, subutex? Yes No Please be aware that these interfere with pain management and need to be converted to another medication 3 - 4 days prior to surgery.
3. Please list all major surgeries/date:
4. Do you have any implanted electrical devices? ( <b>Example</b> : Pacemaker, nerve stimulator) Yes No if yes blease specify
5. Do you have a Lapband®? Yes No Lapband® surgeon: <u>Dr</u>
6. Smoking history: Current: Yes No Former: Yes No Never: Yes No
Quitting pre-operatively improves outcomes.
7. Alcohol: Yes No If yes - number of drinks/week: Former alcohol abuse Yes/No
8. Illicit drug usage: Yes No Current usage includes:
Ebola screening: Have you recently traveled outside of the country? Ghana/Liberia/Sierra Leone. If yes and you have any gastro or flu like symptoms please use a face mask and hand this form to the clerk.
declare the above information to be correct and complete

declare the above information to be correct and complete.

Patient or guardian signature:	Date:

Best contact phone number for you: