Kaiser Permanente Northern California

Pre-surgery Questionnaire

NAME	MEDICAL RECORD NUMBER	DATE

REMEMBER **Bring all Medications and/or a list of your medications with you when you visit the Pre-op Clinic.**

Have you ever had any problems with your: (Please check all that apply)

☐ **HEART/BLOOD VESSELS**
- Heart Attack (coronary)
- Angina (chest pain or pressure)
  If so, how often? _____
- Rhythm Problem (skipped beats, etc.)
- Murmur
- Blood Pressure (high or low)
  If taken at home, usual BP _____
- Other: _____

☐ **LUNGS**
- Asthma / wheezing
  Inhaler use? How often? _____
- Shortness of breath
  If so, when? _____
  How often? _____

☐ **LIVER** (hepatitis, cirrhosis, or jaundice)

☐ **KIDNEYS**
- Dialysis (circle days): M T W Th F S Su

☐ **BLEEDING**

☐ **NERVOUS SYSTEM** (stroke/TIA, dizziness, fainting, seizures)

☐ **THYROID** (high or low)

☐ **STOMACH**
(acid reflux, ulcers, heartburn, hiatal hernia, motion sickness)

☐ **MUSCLE OR BONE**
- Neck, Joint, or Back problems
- Rheumatoid arthritis

☐ **BLOOD SUGAR** (diabetes)
- If you are diabetic and check your sugars in the morning, what is your usual morning pre-breakfast sugar level? _____
- Have you ever had symptoms of low blood sugars? _____
- What is the highest blood sugar you've ever had? _____

Do you have any of the following sleep problems? (Please check all that apply)

☐ Snoring—frequent or loud
☐ Unrestful or poor sleep
☐ Daytime sleepiness
☐ Brief periods of stopping your breath during sleep
☐ Sleep apnea
- Do you use a CPAP machine? ☐ No ☐ Yes

Allergies, Medication, and Social History

Have you had a cold, earache, sore throat, or runny nose within the last month? ☐ No ☐ Yes

Do you have allergies or bad reactions to any drug/medications? ☐ No ☐ Yes Which ones? _____
What happens? _____

Do you take any herbal medicines or over-the-counter supplements? ☐ No ☐ Yes Which ones? _____

Do you smoke? ☐ No ☐ Yes _____ packs/day for _____ years

Do you drink alcohol? ☐ No ☐ Yes _____ drinks per ☐ day ☐ week

Do you use any recreational drugs? (e.g., marijuana, cocaine, heroin, etc.) ☐ No ☐ Yes Which ones? _____

FOR WOMEN: Is there any possibility you could be pregnant? ☐ No ☐ Yes

Have you or a family member ever had any problems with anesthesia? (Malignant Hyperthermia; Pseudocholinesterase deficiency, Other) ☐ No ☐ Yes What happened? _____

Please list all previous surgeries with approximate dates: _____

KAISER PERMANENTE®

Kaiser Permanente Northern California

Pre-surgery Questionnaire

NAME	MEDICAL RECORD NUMBER	DATE

Your activity level

Can you do these things?			MET EQUIV
Check box if YES			
☐	1.	Walk indoors (for example, around your house)?	1.75
☐	2.	Walk a block or two on level ground?	2.75
☐	3.	Do yard work like raking leaves, weeding, or pushing a lawn mower?	4.50
☐	4.	Climb a flight of stairs or walk up a hill?	5.50
☐	5.	Participate in moderate recreational activities like golf, bowling, dancing, doubles tennis, or throwing a baseball or football?	6.00
☐	6.	Participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing?	7.50
☐	7.	Do heavy work around the house (like scrubbing floors, lifting, or moving heavy furniture)?	8.00

What is the most active thing that you did during the last 6 months? _____

_____

_____

KAISER PERMANENTE®