*****Please bring this completed form, insurance cards and a form of identification on the day of your procedure. Thank you.*****

Klamath Surgery Center
2640 Biehn Street
Klamath Falls, OR 97601
PH (541) 884-5559 Fax (541) 884-7727

PRE-OPERATIVE QUESTIONAIRE & EVALUATION

PATIENT NAME_____PRIMARYPHYSICIAN_____PROCEDURE_____

AGE_____SEX_____HEIGHT_____WEIGHT_____PHONE (home)_____WORK _____

Responsible party for postoperative transportation and care: NAME_____ PHONE_____

DO YOU HAVE A <u>SIGNIFICANT</u> HISTORY OR CURRENTLY HAVE:

Y	N	**Neuro**
❒	❒	Seizures/Convulsions/Epilepsy
❒	❒	Strokes/CVA
❒	❒	Black out spells/Loss of memory
❒	❒	Numbness, weakness or paralysis
❒	❒	Blood clots
Y	**N**	**Vascular**
❒	❒	Heart attack
❒	❒	Chest Pains (angina)
❒	❒	Heart Failure
❒	❒	Heartbeat: ❒Irregular❒Skipped❒Fast
❒	❒	Pacemaker
❒	❒	Heart murmur❒Valve❒
❒	❒	High Blood Pressure
Y	**N**	**Lung**
❒	❒	Shortness of breath
❒	❒	Asthma or wheezing
❒	❒	Emphysema/COPD
❒	❒	Frequent bronchitis or pneumonia
❒	❒	Recent cold or infection
❒	❒	TB or other lung problems
Y	**N**	**Abdominal**
❒	❒	Hiatal hernia/Heartburn/Reflux
❒	❒	Ulcer disease
❒	❒	Hepatitis/Cirrhosis
❒	❒	Kidney or urination problems
❒	❒	Other abdominal problems_____
❒	❒	Porphyria (increased amounts of porphyrin)
Y	**N**	**Other**
❒	❒	Diabetes ❒Diet controlled ❒Insulin controlled
❒	❒	Anemia, bleeding or easily bruised
❒	❒	HIV disease
❒	❒	AIDS
❒	❒	Hepatitis C
❒	❒	MRSA (Methicillin resistant staphylococcus)
❒	❒	VRE (Vancomycin resistant enterococci)
❒	❒	c. difficile
❒	❒	Artificial or limited movement joints
❒	❒	Arthritis

*****Please complete both sides of this form*****

*****Please bring this completed form, insurance cards and a form of identification on the day of your procedure. Thank you.*****

❒ ❒ Thyroid

Y	N	
❒	❒	Reaction to any prior anesthetics by: ❒You ❒Family Describe:_____
❒	❒	Airway problems (snoring, sleep apnea, "difficult airway")
❒	❒	Limited mouth opening or neck movement
❒	❒	Dentures, loose/chipped/capped, missing teeth
❒	❒	Motion sickness
❒	❒	Anxiety attacks or claustrophobia
❒	❒	Other diseases, conditions or problems? _____
❒	❒	Physical/Sensory Limitations/Restrictions: _____
		❒Glasses❒Contacts❒Hearing Aid/Hearing Deficit❒Functional Illiteracy❒Other:_____
❒	❒	Do you smoke? Packs per day_____ Number of years_____ Quit Smoking? Year Quit? _____
❒	❒	Do you drink alcohol? _____per day _____ per week
❒	❒	Do you use recreational drugs? _____
❒	❒	FEMALES: Are you or might you be pregnant? Date of last period _____

Allergies (include medications and food) _____

Latex? ❒Yes ❒No Sutures ❒Yes ❒No Type: _____ Tape? ❒Yes ❒No

Food: ❒Eggs ❒Kiwi ❒Guava ❒Soy Bean ❒Other: _____

Reaction: _____

Please List your previous **surgeries or procedures (within the last 5 years)**

_____

_____

_____

Medication History: Have you taken any of the following medications in the last six months?

Drug:	**Name:**	**Dsg**	**Drug:**	**Name:**	**Dsg**	**Drug:**	**Name:**	**Dsg**
❒Steroids	_____	___	❒Aspirin	_____	___	❒Diabetic Meds	_____	___
❒Birth Control	_____	___	❒Arthritic Meds	_____	___	❒Thyroid Meds	_____	___
❒Antibiotics	_____	___	❒Tranquilizers	_____	___	❒Blood Pressure	_____	___
❒Anti-Coagulants	_____	___	❒Narcotics	_____	___	❒Heart Meds	_____	___
❒Antihistamines	_____	___	❒IV/Rec drugs	_____	___	❒OTC	_____	___
❒Herbal Med	_____	___	❒Home remedy	_____	___	❒Other	_____	___

_____

_____

Pain History and Assessment:

Do you have pain associated with the condition for which you are awaiting surgery? ❒Yes ❒No

If yes, on a scale of 1 to 10, with 10 being the most severe, describe this pain (circle): **10 9 8 7 6 5 4 3 2 1**

What do you now do for pain relief?_____

Do you hesitate to take pain medication? ❒Yes ❒No

Does pain medication prescribed in the past provide pain relief? ❒Yes ❒No

What works best for you? _____

Signature_____**Date**_____**Time**_____

*****Please complete both sides of this form*****