



The Department of Anesthesiology and Internal Medicine at the Texas Tech University Health Sciences Center and the Outpatient Surgery Center of University Medical Center have developed this questionnaire in order to make the process of preparing you for your outpatient surgery more efficient.

Both a nurse and the anesthesiology team will review this information with you. They will do their best to answer whatever questions that you may have.

We thank you very much for your time.

Dear Patient

Please keep this page

SOME THINGS TO REMEMBER:

Adults:

Adult patients must not eat or drink anything after midnight on the night before surgery. Your doctor will instruct you on the medications you may take. If your surgeon or anesthesiologist requests that you take a medication on the morning of surgery, please take it with a sip of water only. If you have trouble swallowing pills with water, please call us at UMC's Outpatient Surgery Center, and ask for advice, Monday through Friday, 9 a.m. to 5 p.m. at 806-775-8525.

You must arrange for an adult to take you home from the hospital. You cannot drive yourself home. This person should be able to act on your behalf if necessary.

Children Only:

Children may not have milk or solid food after midnight on the night before surgery. They may have clear liquids up until four hours before they are supposed to arrive at the hospital. Clear liquids include water, apple juice, Pedialyte or sugar water.

Babies should be given clear liquids up until four hours before they are supposed to arrive at the hospital. Infants should be awakened if necessary to give them some clear liquids.

Surgery Schedule:

Surgery schedules are difficult to estimate. Unexpected delays occur and waits may be unavoidable. Please plan to be in the Outpatient Surgery Center all day.

Illness:

Fever, colds or other conditions may cause problems during your surgery. If you become ill prior to the day of your surgery, please call us at Outpatient Surgery Center, so that we can make sure that you are ready for surgery. You may call 806-775-8525, Monday through Friday, 9 a.m. to 5 p.m. After hours please notify your surgeon.

OUR GOAL IS TO PROVIDE YOU WITH VERY GOOD CARE

Please answer the following questions. Please circle **Yes** or **No** or fill in the blank, as appropriate. Place a check mark (✓) beside any question that you are not sure how to answer. After completing the form please return it to the indicated party: your surgeon's office staff or the UMC outpatient staff, or the anesthesiologist.

A. Patient Information

Patient Name: _____ Date: _____
DOB: _____ Age: _____

Do you have any specific concerns regarding your anesthesia? **Yes** **No**
Please tell us about them.

What is your surgeon going to do for you? _____
What gender are you? **(Circle one)** **Male** **Female**
How much do you weigh? _____
How tall are you? _____

B. Healthcare Provider Information

Do you have a regular physician? **No** **Yes**

Name/Title _____ Phone(____) _____

Clinic Name/Address _____

Do you have a heart doctor? **No** **Yes**

Name/Title _____ Phone(____) _____

Clinic Name/Address _____

C. Medications

Please list any prescription and /or non-prescription medications including vitamins, supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbs and cold medications you are currently taking.

I am not taking any medications

Name of Medication	Dose (Strength)	How often taken (e.g. 2 x a day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken aspirin containing products within the last 2 weeks? **No** **Yes**
Have you taken steroid or cortisone type drugs within the last year? **No** **Yes**
Do you take antibiotics prior to dental work or any other procedures? **No** **Yes**

Please write down the name and address of your pharmacy: _____

D. Allergies

Are there any medication to which you have had an allergic reaction or unpleasant side-effects?

No Yes

If yes, please describe in the space below. If more than space allows, please provide list to the nurse.

Name of Medication	Reaction
_____	_____
_____	_____
_____	_____

Are you allergic to any foods? No Yes

Please list the food and describe what happened when you ate that/those food items:

<u>Food</u>	<u>Reaction</u>
_____	_____
_____	_____

Are you allergic to anything else such as tape or iodine? No Yes

E. Systems Review & Past Medical History

Breathing Problems:

- Do you have any problems with breathing? **Yes No**
- Asthma? **Yes No**
- Emphysema or bronchitis? **Yes No**
- Have you had a cold within the last month? **Yes No**
 If so, how long ago did you start to feel better? _____
- How many years have you smoked? _____
- Do you use oxygen at home? **Yes No**

Heart or Blood Pressure Problems:

- Have you ever been told by a doctor that you have heart disease or That you have had a heart attack? **Yes No**
- Have you ever had chest pain? **Yes No**
- Have you ever had a study done on your heart? **Yes No**
 - If yes, when did you have it done? _____
 - If yes, where did you have it done? _____
- Do you have high blood pressure? **Yes No**
- How far can you walk before you get short-of-breath _____

Other Circulatory Problems:

- Have you ever had a stroke? **Yes No**
- Do you have problems with your blood vessels? **Yes No**
- Do you bleed easily? **Yes No**
- Have you ever been told that you were anemic? **Yes No**

Other Diseases:

- | | | |
|-------------------------------------|------------|-----------|
| ➤ Do you have heartburn frequently? | Yes | No |
| ➤ Do you have arthritis? | Yes | No |
| If so, is it rheumatoid arthritis? | Yes | No |
| ➤ Do you have muscle disease? | Yes | No |
| ➤ Have you ever had a seizure? | Yes | No |
| ➤ Do you have thyroid disease? | Yes | No |
| ➤ Do you have diabetes? | Yes | No |
| ➤ Do you have kidney disease? | Yes | No |
| ➤ Do you have liver disease? | Yes | No |
| ➤ Have you ever had hepatitis? | Yes | No |

Dental Problems:

- | | | |
|--|------------|-----------|
| ➤ Do you have loose teeth? | Yes | No |
| ➤ Do you have removable dental appliances? | Yes | No |
| ➤ Do you have permanently implanted dental appliances? | Yes | No |

Accessories:

- | | | |
|--|------------|-----------|
| ➤ Do you wear glasses or contact lenses? | Yes | No |
| ➤ Do you have body piercings? | Yes | No |

F. Social History

What do you do for a living? _____

How much alcohol do you consume in the average week? _____

- | | | |
|---|------------|-----------|
| ➤ Have you ever smoked tobacco? | Yes | No |
| ➤ If so, how many packs of cigarettes did you smoke at most during one day? | | |

_____	Yes	No
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Have you ever used recreational drugs?

G. Past Surgeries:

What operations have you had in the past? Please list.

<u>Operation</u>	<u>Year</u>
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had a problem with anesthesia? If yes, please tell us about it.	Yes	No
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As far as you know, has anyone in your family ever had a problem with anesthesia If yes, please tell us about it.	Yes	No
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