BRIGHAM AND WOMEN'S/MASS GENERAL
HEALTH CARE CENTER

Fax to 508-718-4056

Name:_____ MR#:_____ PRE-SURGERY QUESTIONNAIRE

This information will help us prepare for your anesthesia and surgery. Please fill out as completely as you can.

Date of surgery:_____/_____/_____

Age: Height:_____ Weight: _____ Surgery:_____

What is your sex? ☐ Male ☐ Female Surgeon:_____

Primary MD:_____ Primary MD phone #: _____-_____-_____

A nurse usually calls 1 to 2 weeks before your surgery to do an evaluation. We call Monday through Friday between the hours of 9 AM and 3:30 PM. What is(are) the phone number(s) we can use to easily reach you?

_____-_____-_____ best ☐ cell ☐ home ☐ office _____-_____-_____ other ☐ cell ☐ home ☐ office

We make calls several times a day. What are the 2 best times we can try to reach you? _____,_____

Have you or a family member (related by blood) ever had a serious reaction to
anesthesia (other than nausea and vomiting)? ..... ☐ Yes ☐ No
If yes, was it called Malignant Hyperthermia …….. ☐ Yes ☐ No ☐ Don't know

If you have had surgery, were you told it was hard to put in a breathing tube? … ☐ Yes ☐ No Use this area to explain:

Do you have any difficulty opening your mouth or moving your head or neck? … ☐ Yes ☐ No

Have you ever had a heart attack or myocardial infarction?..... ☐ Yes ☐ No
If yes, was it in the past 8 weeks? ……. ☐ Yes ☐ No
When was your heart attack? _____/_____/_____

Do you have a pacemaker for your heart? ……. ☐ Yes ☐ No

Do you have an internal defibrillator for your heart? …… ☐ Yes ☐ No

Do you have a problem with breathing? …… ☐ Yes ☐ No
If yes, are you on oxygen? …… ☐ Yes ☐ No
Have you gone to an emergency room or been hospitalized for a
breathing problem in the past month?..... ☐ Yes ☐ No

Do you have sleep apnea? ……. ☐ Yes ☐ No
If yes, are you, or are you supposed to be on, a CPAP machine? ☐ Yes ☐ No

Do you have diabetes or a problem with high blood sugars? …… ☐ Yes ☐ No
If yes, do you have a problem keeping your diabetes under control?
If you have diabetes, are you taking insulin? …… ☐ Yes ☐ No

Are you on dialysis for your kidneys? …… ☐ Yes ☐ No

Do you bruise easily? ……. ☐ Yes ☐ No

When you get a cut, is it hard to stop the bleeding? ……... ☐ Yes ☐ No

Have you ever had blood clots in your legs or your lungs? ……. ☐ Yes ☐ No

If there anything special about you, or in your life situation, that would make
it hard for you to go home after surgery?..... ☐ Yes ☐ No
If yes, please explain:_____

If female, when was your last menstrual period? _____/_____/_____
Could you be pregnant? ……. ☐ Yes ☐ No

If you have had any surgeries, please list them all:_____
_____

Do you get sick to your stomach, throw up, or have nausea after surgery? ……. ☐ Yes ☐ No

Do you get motion sickness? ……. ☐ Yes ☐ No

In the past 6 months, have you taken any steroids (like prednisone) by mouth? ☐ Yes ☐ No
If yes, did you take it more than 10 days

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Medication	Dose and Frequency	Medication	Dose and Frequency

List all your allergies to medications, LATEX, shellfish, iodine, dye, eggs or other food. ☐ No allergies

Medication/Substance	Type of Reaction

Are you being treated for high blood pressure? …….. ☐ Yes ☐ No
If yes, is your blood pressure well controlled?..... ☐ Yes ☐ No
Are you taking a fluid pill, water pill, or diuretic?..... ☐ Yes ☐ No
Do you have, or have you ever had any problems with your heart?..... ☐ Yes ☐ No
If yes, is it or was it
A heart murmur or problems with a heart valve?…….. ☐ Yes ☐ No
A problem with your heart rhythm?..... ☐ Yes ☐ No
Angina or chest pain?..... ☐ Yes ☐ No If yes, when was the last time?___
Heart failure or fluid in your lungs? …… ☐ Yes ☐ No If yes, when? _____
Have you ever had an EKG? …… ☐ Yes ☐ No If yes, when? _____
Have you ever had a stress test? …… ☐ Yes ☐ No If yes, when?_____
Have you had a cardiac echo or ultrasound?..... ☐ Yes ☐ No If yes, when? _____
Have you had heart catheterization?..... ☐ Yes ☐ No If yes, when? _____
If yes, did you have stents placed? …… ☐ Yes ☐ No
Have you ever had a stroke? …… ☐ Yes ☐ No If yes, when _____
If yes, do you still have any weakness? …… ☐ Yes ☐ No If yes, what is weak? _____
Have you ever had a seizure? …… ☐ Yes ☐ No If yes, when was the last? _____
Have you ever fainted or passed out? …… ☐ Yes ☐ No If yes, when was the last? _____
Have you ever had hepatitis? …… ☐ Yes ☐ No
If yes, is it still active? …… ☐ Yes ☐ No
Do you have a hiatal hernia? …… ☐ Yes ☐ No
Do you have a problem with acid reflux? …… ☐ Yes ☐ No
If yes, is it under control? …… ☐ Yes ☐ No
Do you smoke? …….. ☐ Yes ☐ No If yes, how much? _____
If you do no smoke now, did you ever smoke? …… ☐ Yes ☐ No If yes, when did you stop? _____
Do you drink alcohol? (beer, wine, etc.) ……. ☐ Yes ☐ No If yes, how much? _____
Have you had a problem with alcohol? …….. ☐ Yes ☐ No If yes, when? _____
Have you had a problem with addiction?…….. ☐ Yes ☐ No If yes, what and when? _____
Have you used any recreational drugs in the past month? …… ☐ Yes ☐ No If yes, what and when? _____
(marijuana, cocaine, etc.)

If you have had any major illnesses or hospitalizations, please describe and give the approximate date:

Illness or Hospitalization	Date