Pre-Operation Questionnaire

Please complete all information below.

WASHINGTON INSTITUTE ORTHOPEDIC CENTER

Patient Information

Patient Name: _____ Date of Birth: _____

Doctor's Name: _____ Today's Date: _____

Preferred Pharmacy: _____

Pharmacy Location: _____

What body part(s) is this visit regarding?

SHOULDER: ☐ Left ☐ Right **ELBOW:** ☐ Left ☐ Right **WRIST:** ☐ Left ☐ Right

HAND: ☐ Left ☐ Right **HIP:** ☐ Left ☐ Right **KNEE:** ☐ Left ☐ Right

ANKLE: ☐ Left ☐ Right **FOOT:** ☐ Left ☐ Right

OTHER: _____

Please answer all of the following:

1. Since your last visit, how are you feeling? ☐ Better ☐ Worse ☐ Same
2. On a scale of 0 to 10 (10 is worst), what is the severity of your pain? (circle one): 0 1 2 3 4 5 6 7 8 9 10
3. Do you have, or have you had, any of the following conditions:
   a. Heart issues (e.g. high cholesterol, high blood pressure) ☐ Yes ☐ No
   b. Do you have a cardiologist? ☐ Yes ☐ No If "Yes," physician's name: _____
   c. History of blood clot(s) ☐ Yes ☐ No
   d. Breathing problems (e.g. asthma, sleep apnea, COPD) ☐ Yes ☐ No
   e. Do you use a CPAP or BiPAP machine? ☐ Yes ☐ No
   f. Hepatitis or liver trouble ☐ Yes ☐ No
   g. Kidney problems ☐ Yes ☐ No
   h. Do you have a nephrologist? ☐ Yes ☐ No If "Yes," physician's name: _____
   i. Epilepsy, seizures, or fits ☐ Yes ☐ No
   j. Glaucoma ☐ Yes ☐ No
   k. Bleeding disorders (e.g. Sickle cell, hemophilia) ☐ Yes ☐ No
   l. Gastrointestinal problems (e.g. acid reflux, hernia, ulcer, heartburn) ☐ Yes ☐ No
   m. Diabetes ☐ Yes ☐ No If "Yes," when was last AIC: _____
4. Have you had any blood drawn or an EKG in the last 60 days? ☐ Yes ☐ No
5. Do you have a history of anesthesia problems? ☐ Yes ☐ No
6. Do you have a family history of anesthesia problems? ☐ Yes ☐ No
7. Any chance of pregnancy? (women only) ☐ Yes ☐ No
8. Do you smoke (including marijuana)? ☐ Yes ☐ No If "Yes," how often? _____
9. Do you drink alcohol? ☐ Yes ☐ No If "Yes," how much? _____

List all previous surgeries:

Previous Surgery	Date

Do you have any metal in your body? ☐ Yes ☐ No If "Yes," list where: _____

Please complete the reverse side of this form.

Form 04001 – Rev. 091318

List *ALL* allergies:

Check if you have allergies to: ☐ Latex ☐ Tape ☐ Iodine

Allergy	Reaction

List all medications including over-the-counter (OTC) medications and supplements you are taking:

Name of Medication	Dosage	Frequency

Patient Signature: _____ Date: _____

MD/PA-C Signature: _____ Date: _____

For Office Use Only

Blood Pressure: _____ Pulse: _____

Height: _____ Weight: _____ BMI: _____