Dartmouth-Hitchcock

PREOPERATIVE PATIENT HEALTH ASSESSMENT

Questions for the patient or parent:
If the patient has had surgery before, please check any of these that happened:

- ❑ Have you ever had a problem with Anesthesia?
- ❑ Problem putting in a breathing tube
- ❑ Sick to stomach after surgery
- ❑ Had an allergic reaction
- ❑ Took a long time to wake up
- ❑ Had to be in the hospital overnight when that wasn't the plan
- ❑ *Have you or anyone in your family been told that he or she has "malignant hyperthermia"?*

Please check any of the following that apply to you (or the patient, if you are the parent answering for a child):

QUESTIONS ABOUT BREATHING WHILE YOU SLEEP:

- ❑ I cannot lie flat to sleep at night because it makes me short of breath
- ❑ I snore so loud that people can hear me through the wall
- ❑ I have been told that I sometimes stop breathing in my Sleep
- ❑ I fall asleep during the day when I don't plan to
- ❑ I often feel tired or sleepy during the day
- ❑ I am a male and the neck size for my button up shirts is over 17 inches
- ❑ I have been told that I have obstructive sleep apnea.

ANSWER ONLY IF YOU HAVE OBSTRUCTIVE SLEEP APNEA

- ❑ I have been told that I should use CPAP
- ❑ I USE/DONT USE CPAP

OTHER QUESTIONS:

- ❑ I am or could be pregnant
- ❑ I have to stop to catch my breath when I climb one set of stairs
- ❑ I smoke
- ❑ I have lung problems (asthma, emphysema, or COPD)
- ❑ I use home oxygen
- ❑ I have a transportable oxygen source
- ❑ I have High Blood Pressure
- ❑ I have had a heart attack
- ❑ I have had a coronary stent placed Date: _____
- ❑ My chest pain has recently gotten worse
- ❑ I have a heart valve problem
- ❑ I have congestive heart failure
- ❑ I cannot lie flat on my back for half an hour
- ❑ I have a pacemaker
- ❑ I have an implanted automatic defibrillator (an "AICD")
- ❑ I have had a stroke or a "temporary stroke" (TIA)
- ❑ I take blood thinners (name: _____
- ❑ I use a wheelchair or walker, or have difficulty with movement.
- ❑ I have muscular dystrophy or a nerve disease (like Lou Gehrig's Or Myasthenia Gravis)
- ❑ I have seizures
- ❑ I have acid reflux/GERD or a hiatal hernia
- ❑ I have diabetes - **not** taking insulin
- ❑ I have kidney disease
- ❑ I am on Dialysis (Days of week _____ _____
- ❑ I have a clotting Disorder: _____ _____
- ❑ I have had radiation or surgery for head or neck cancer
- ❑ I have difficulty opening my mouth
- ❑ I have had an organ or bone marrow transplant
- ❑ I have sickle cell disease

DI drink more than 2 glasses of wine or beer or 1 "hard" drink on most days

- ❑ I get car sick or motion sick
- ❑ I have an inherited disorder or genetic syndrome
- ❑ Do you currently take medications called "opioids" (OxyContin, Oxycodone, MS Contin, Methadone, Suboxone) for a chronic pain condition?
- ❑ Do you have a contract for long term controlled substance prescriptions? Provider: _____

IF THE PATIENT IS YOUR CHILD:

Was your child born prematurely? Less than 37 weeks ..... YES
I If **yes,** was oxygen or a ventilator needed?..... YES
Does your child have Congenital Heart Disease? ..... YES
Does your child have a Genetic Syndrome?..... YES
Does your child have Cerebral Palsy? ..... YES
Has your child been diagnosed with metabolic disease? ..... YES
Does your child have Autism or developmental delay? ..... YES
Has your child been sick in the past week? ..... YES
Has your child been admitted to the hospital in the last three months?..... YES

OTHER QUESTIONS:

Patient's Signature: _____

Date: _____

For Office Use Only:

Information from the Surgeon's Office: Patient's Height: _____ (cm) Patient's Weight: _____ (kgs) Patient's BMI: _____

Planned procedure: _____ Planned date of procedure: /___ /___

ANESTHESIA PROVIDER: I have reviewed this information. The plan is:

- ❑ **NLH Approved** with no further work up needed.
- ❑ **NLH Approved** but needs the following tests or consults:
  - ❑ PAT CONSULT ❑ PCP CONSULT ❑ LABs ❑ OTHER: _____
- ❑ **NLH Denied**-Reason: _____

Anesthesiologist Signature: _____