

## Richfield Medical Group Pre-Op Questionnaire

What type of surgery are you having? \_\_\_\_\_

Who is your surgeon? \_\_\_\_\_

What is the reason for surgery? \_\_\_\_\_

Date of your surgery \_\_\_\_\_

Hospital/Surgery Center Location \_\_\_\_\_

Fax Number for hospital/surgery center \_\_\_\_\_

Do you have a Healthcare Directive or Living Will? \_\_\_\_\_

Please answer each question by making an "X" in the appropriate box. Thank You!

### Yes No

1.   Do you have a history of heart attack, stroke, stent, bypass or surgery on an artery in the head, neck, heart or legs? Circle which one
2.   Do you ever have any pain or discomfort in your chest?
3.   Do you have a history of heart failure? If yes, when \_\_\_\_\_
4.   Are you troubled by shortness of breath when: walking on the level, up a slight hill or at night?
5.   Do currently have a cold, bronchitis or other respiratory infection?
6.   Do you have a cough, shortness of breath or wheezing?
7.   Do you sometimes get pains in the calves of your legs when you walk?
8.   Do you or anyone in your family have previous history of blood clots?
9.   Do you or anyone in your family have a serious bleeding problem such as prolonged bleeding following surgeries or cuts?
10.   Have you ever had problems with anemia or been told to take iron pills?
11.   Have you had any abnormal blood loss such as black, tarry or bloody stools, or abnormal vaginal bleeding?
12.   Have you ever had a blood transfusion? If yes, when \_\_\_\_\_
13.   Have you or any of your relatives ever had problems with anesthesia?
14.   Do you have sleep apnea, excessive snoring or daytime drowsiness?
15.   Do you have any prosthetic heart valves?
16.   Do you have any prosthetic joints?
17.   Is there any chance you may be pregnant?