

Pre-Op Admission Form/ Health Survey Questionnaire

Name _____ Age _____ Sex _____ Dr. _____ Anes _____
 Procedure _____
 Date _____ Time _____ Person Answering Patient Parent Other _____
 Escort/Driver _____ Overnight Escort _____
 Emergency Contact _____ Relationship _____ Phone Number _____
 Medications _____

 OTC/Natural/Herbals _____

 ASA or Coumadin _____ Drug Allergies/Reactions _____

 Food Allergies/Reactions _____
 Latex Allergy/Reaction Yes No _____ Surgical History _____

Pre-Op Admission - Completed Day of Surgery

Patient ID Verified: Name DOB ID Band Consent Reviewed/Signed Void Yes No
 NPO Since _____ Cold/Illness Yes No Open Cuts/Sores Yes No on _____
 Medications Taken Today _____
 Contact Lenses Removed Dentures ↑ ↓ Removed Hearing Aid R L Removed
 All Jewelry Removed Nail Polish Removed Yes No Prep Done By _____
 IV Type _____ Amount _____ Angio Gauge # _____ Infusion Rate _____ Started By _____ @ _____ Xylo Wheal
 IV Lock Site c NS Flush _____ Angio Gauge # _____ Started By _____ @ _____ Xylo Wheal

MEDICATIONS					
Drug	Dose	Route	Site	Time	Signature
Lidocaine Jelly 2%		topical			
Vigamox		topical			
Acular		topical			
Phenylephrine 10%		topical			
Cyclogyl 1%		topical			
1 dram Lidocaine jelly mixed with 8 drops of each medication. Each patient receives 0.25ml					



Place X at angio site
 Pain Management Orientation
 Present Level of Pain _____
 Location _____
 Verbal Understanding of Pain Scale

Comments: _____

Physical Eval: T _____ P _____ R _____ BP _____ / _____ 02Sat _____ Ht _____ Wt _____ Accucheck _____ Ua Preg _____
 Admitting Nurse _____ Date _____ Time _____
 Block Y N Scalene Femoral Sciatic Eyeblock Time Out
 Post Block Vital Signs P _____ R _____ BP _____ / _____ 02Sat _____ Time _____ Signature _____
 Comments: _____



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Health Survey Questionnaire

- 1 Have you ever had a problem with anesthesia?
- 2 Has anyone related to you ever had a problem with anesthesia?
- 3 Could you be pregnant? Date of last menstrual period _____ BTL/Hysterectomy
- 4 Do you have any breathing problems? Bronchitis COPD Cancer Asthma
 Inhalers Sleep Apnea Cough Y N Productive Y N
- 5 Have you ever had an abnormal chest x-ray?
- 6 Do you have any difficulty lying flat on your back?
- 7 Do you have any heart problems? Heart Attack Chest Pain HTN
 Heart Murmur Heart Surgery Cardiac Stent CABG
- 8 Do you have a defibrillator or pacemaker? Date last checked _____
- 9 Do you have diabetes? Insulin Oral meds Diet
- 10 Do you have any stomach or GI problems? Ulcer Hiatal Hernia GERD
- 11 Have you ever had a stroke Epilepsy Fainting Spells TIA Tremors
- 12 Do you have any communicable diseases? TB Hepatitis Jaundice
- 13 Do you have any eye problems or diseases? Glaucoma
- 14 Do you have any kidney problems? Dialysis
- 15 Do you have any numbness, tingling or weakness in your arms or legs?
- 16 Do you have any chipped or loose teeth, dentures, caps, bridgework, braces,
 difficulty with your jaw, or opening your mouth? TMJ
- 17 Do you smoke, drink alcohol, chew tobacco, or use recreational drugs?
- 18 What is your height _____ weight _____
- 19 Do you have any medical problems not mentioned?
- 20 Are you feeling anxious about surgery?
- 21 Have you received written preoperative instructions?

NO	YES	Comments

PAT	WHERE	WHEN	
CXR			
EKG			
LABS			
Cardiac Clearance			
Stress Test			
Other			
Primary Care Physician: _____			
Specialist: _____			
Health History Unchanged from Previous Visit _____			

Pre-op Teaching/Instructions
 Nothing to eat after 12 MN. Clear liquids until 2 hrs before surgery. No gum or candy (water, apple juice, clear soda, black coffee or tea – no sugar/milk)
 Breast milk may be consumed up to 4 hrs before surgery.
 Infant formula may be consumed up to 6 hrs before surgery.
 Wear loose, comfortable clothing.
 If receiving sedation or anesthesia, you may not drive for 24 hrs and must have a responsible adult with you for 24 hrs
 Do not wear make-up, nail polish, or jewelry. All piercings must be removed before surgery. Leave valuables at home.
 General anesthesia patients should eat light foods after surgery
 If child uses bottle or special cup please bring it the day of surgery
 Discontinue use of all herbal products 2 weeks before surgery
 Do not take oral hypoglycemics and/or diuretics the morning of surgery
 Child-bearing age females- urine pregnancy test day of surgery
 Pain management scale explained (0 – 10), Present pain level _____
 Anticoagulants, Insulin, ASA to be instructed per physician.
 Take meds with sip of H₂O: _____

RN Signature _____ Date _____

MD, DO Signature _____ Date _____