NEW BRUNSWICK PRE-OPERATIVE QUESTIONNAIRE

Patient Name : _____
Medicare Number : _____

Address :

Daytime/work phone : _____
Cell number : _____
Home phone : _____

Date of Birth _____ (yyyy/mm/dd)
Height : _____
Weight: _____

Family Doctor :

Surgeon :

Who completed this form? Patient ☐ Other ☐
Name/relationship : _____
Date completed (yyyy/mm/dd) _____

1. Do you smoke? YES ☐ NO ☐ How many per day? _____ Number of years you have smoked? _____
2. Have you ever smoked? YES ☐ NO ☐ When did you quit? _____
3. Is it possible that you are pregnant? YES ☐ NO ☐
4. Do you take warfarin, coumadin, aspirin, or Plavix or any blood thinner? YES ☐ NO ☐
5. Have you taken prednisone, cortisone, or steroids (excluding inhalers) in the past 12 months? YES ☐ NO ☐

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

	YES	NO		YES	NO
6. Difficulty with neck movement or opening your mouth?	☐	☐	20. Blackouts or fainting spells in the last year?	☐	☐
7. Capped, loose, false teeth or body piercings?	☐	☐	21. Stroke, mini-stroke, severe muscle weakness, or paralysis of any part of your body?	☐	☐
8. Asthma, bronchitis, COPD, TB?	☐	☐			
9. Are you on Home Oxygen?	☐	☐	22. Epilepsy, seizure, or a significant neurological disorder?	☐	☐
10. Chronic or troublesome cough?	☐	☐	23. Kidney disease?	☐	☐
11. Shortness of breath at rest or when lying flat?	☐	☐	24. Thyroid problems ?	☐	☐
			25. Diabetes?	☐	☐
12. Sleep apnea (stop breathing in your sleep)?	☐	☐	26. Yellow jaundice, hepatitis, AIDS, or liver problems?	☐	☐
13. Shortness of breath when walking up two flights of stairs?	☐	☐	27. Rheumatoid arthritis (not osteoarthristis)?	☐	☐
14.a) An unusual or serious reaction to any kind of anesthetic?	☐	☐	28. Bruise or bleed excessively?	☐	☐
b) Does this apply to anyone else in your family?	☐	☐			
15. Nausea or vomiting after an anesthetic?	☐	☐	29. Leg or lung blood clots or DVT?	☐	☐
16. Heart problems such as heart murmur, valve replacement, or serious rhythm disorder?	☐	☐	30. Current low blood count, current anemia, or other blood disorder?	☐	☐
17. Angina, heart attack or cardiac stent?	☐	☐	31. Chronic or acute pain requiring prescription medication?	☐	☐
18. Chest pain with exercise?	☐	☐	32. Hiatus hernia or significant problems with stomach acid or heartburn?	☐	☐
19. High blood pressure?	☐	☐	33. Exposure to MRSA or VRE in the past 12 months?	☐	☐

PLEASE FILL OUT THE FRONT AND BACK OF THIS FORM **PATIENT RECORD** **DH 10/07**

34. Do you drink alcohol, wine, or beer? YES ☐ NO ☐
How much? _____ How often? _____

35. Do you use recreational drugs? YES ☐ NO ☐
Type _____ How often? _____

36. Who will drive you home and stay with you after discharge from the hospital?
Name/relationship : _____

37. List any major illnesses (including psychological) or operations you have had : Include where and when you had the operation.

_____

38. When was the last time you were in the hospital? _____
Where? _____ Why? _____

39. When was the last time you had a general anesthetic? _____
What hospital? _____

40. Are you allergic to LATEX? YES ☐ Reaction : NO ☐

41. Do you have any other allergies? YES ☐ NO ☐
If Yes, then list all allergies you have : (Please ask for an extra form if there is not enough room below)

Allergic to :	**Reaction :**	**Allergic to :**	**Reaction :**

42. Do you take any medications? YES ☐ NO ☐
List and bring all medications, including prescription, herbal and over the counter :
(Please ask for an extra form if there is not enough room below)

DRUG	**DOSE (mg)**	**How often**	**Reason**

HOSPITAL USE ONLY below this line :

Preliminary Screening reviewed by _____ Date _____

Nurse Consult : by Phone ☐ or Clinic visit ☐

Anesthesia consult required: YES ☐ NO ☐

Nurse Consult completed by _____ _____ Date _____
Name Initials (yyyy/mm/dd)