



Patient Name \_\_\_\_\_  
 D.O.B. \_\_\_\_\_  
 Date of Procedure/Surgery \_\_\_\_\_

UNIVERSITY POINTE SURGICAL HOSPITAL  
 PATIENT ASSESSMENT AND PREOPERATIVE NURSES NOTES

Proposed Surgery _____	<b>HAVE NOW OR A HISTORY OF?</b>		<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>	
Phone # _____	Heart Disease					
Alternate # _____	Chest Pain or Angina				If C Pap -bring DOS	
Allergies _____	Heart Attack / M.I.					
IN THE PAST 6 MONTHS I HAVE TAKEN Diet Pills Steroids Blood Thinner Chemotherapy Radiation Tx	Congestive Heart Failure					
<b>DAILY DIET</b>	Irregular / Skipped Beats					
<b>PAST SURGERY</b> _____	Heart Murmur / Rheumatic Fever					
_____	Mitral Valve Prolapse					
_____	Pacemaker					
_____	High Blood Pressure					
<b>HAVE NOW OR A HISTORY OF?</b>	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>			
Have you ever had an unusual or bad reaction to a local or general anesthesia?			A Cold Presently			
Pertinent Family Medical or Anesthetic History			Cough Up Blood / cough>3 weeks			
Any blood transfusions?			Bronchitis / Recent pneumonia			
Any surgery in the past year?			Sleep Apnea/C Pap Use			
Do you smoke? ____ packs per day			Respiratory (Lung) disease			
Do you drink alcohol?			Emphysema / Shortness of Breath			
Recent cocaine / IV drug use?			Asthma			
Ever addicted to drugs or alcohol			TB or Other Lung Disease			
HIV + AIDS / AIDS Risk Factors			Diabetes			
Dentures / Partial Plates			Low Blood Sugar			
TMJ / Jaw Problems			Thyroid Problems			
Glaucoma			Kidney Disease			
Infection such as MRSA or VRE			Bleeding Problems / Blood Disease			
Pregnant / Missed a period?			Anemia / Sickle Cell Disease			
Last Menstrual Period? Mo. _____ Day _____			Ulcers / Hiatal Hernia / Heartburn			
Lactating Currently?			Jaundice / Hepatitis / Liver Disease			
Appetite Changes?			Muscle Dystrophy / Weakness			
Unintended wt. Loss/Gain			Convulsions / Epilepsy / Seizures			
Nausea/Vomiting/Diarrhea 3 or more days?			Stroke / Polio / Paralysis / MS			
Difficulty swallowing/chewing?			Passed Out Recently / Syncope			
Do you feel unsteady when you walk?			If yes Level II falls precautions	Back or Disc Problems / Arthritis		
Any history of recent falls?			If yes Level II falls precautions	Cancer		
Sensitivity to latex, band aids or tape			If yes complete latex questionnaire	Other Illness		

