NewYork-Presbyterian

☐ Insulin pump ☐ Other:__



PRE-PROCEDURE SCREENING TOOL

Please print clearly IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO. Name:__ _ MRN:___ Date of Birth:____/___/ Age:_____ Gender (circle one): M / F Preferred Phone: () _____ - ____ Your E-mail: Best time to call: May we leave a message (circle one)? Yes / No _____ Do you need a translator on the day of surgery (circle one)? Yes / No Preferred language:____ Do you have sight and/or hearing impairment (circle one)? Neither / Sight / Hearing / Both Surgeon (full name): Christopher Barbieri, MD, PhD Expected Date of Surgery: _____/____ Expected procedure: _____ Primary Care Physician (full name):______ Phone: (______ Phone: (Cardiologist (full name):_____ Height (in feet and inches):_____ Weight (in lbs.):_____ Please list all current medical conditions: Please list all allergies (medication, food) and reaction: Please list all medications you are currently taking (including herbal supplements) and dose: Please list all prior surgeries and dates: Please check the boxes below to indicate if you have experienced any of the following problems with prior surgery or anesthesia (you may select more than one): ☐ Severe nausea/vomiting ☐ Problems placing breathing tube ☐ Nerve injury ☐ Slow wake up after anesthesia ☐ Personal/Family history of Malignant Hyperthermia ☐ Other:_ Do you...? If applicable, date quit? How much/often? How many years? Smoke cigarettes? Drink alcohol? Use recreational drugs? ☐ I'd prefer to answer in person **IMPLANTS** (please bring your wallet card on the day of surgery): ___ Last check-up?___ Do you have a pacemaker or an internal defibrillator (circle one)? Yes / No Brand?____ Do you have an artificial heart valve (circle one)? Yes / No ☐ Biologic valve ☐ Mechanical Valve

Do you have any implantable devices (check all that apply): \square PICC \square Broviac \square Dialysis catheter \square Fistula \square Ventricular device

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IF NO PLATE, PRINT NAME, SEX AND MEL	DICAL RECORD NO.	
Please answer the following questions by putting a check mark in the appropriate box (Yes or No):		
	Yes	No
Have you ever had a heart attack or cardiac bypass operation?		
Do you have stents in any artery in your brain or body?		
If yes, please ask your surgeon to complete the Stent Letter		
Do you have high blood pressure?		
Have you been diagnosed with congestive heart failure?		
Do you have atrial fibrillation or atrial flutter?		
Can you walk 2 city blocks or up 1 flight of stairs without stopping due to shortness of breath or chest pain?		
Do you have COPD or Asthma?		
Do you use a rescue inhaler (Albuterol) more than twice a week?		
Hospitalized for COPD/Asthma attack?		
Do you use supplemental oxygen at home?		
Have you been diagnosed or suspected to have Obstructive Sleep Apnea (OSA)?		
Do you use a BiPAP or CPAP machine at home?		
Do you have trouble lying flat on your back?		
If yes: ☐ because of pain ☐ because of breathing difficulty		
Do you have abnormal kidney function?		
Are you on Dialysis?		
Do you have Diabetes?		
Do you take insulin?		
Do you have? ☐ HIV? ☐ Hepatitis A? ☐ Hepatitis B? ☐ Hepatitis C?		
Have you been diagnosed with cirrhosis?		
Have you ever had a seizure?		
Have you ever had a stroke or surgery on your carotid arteries?		
Do you have any chronic pain that requires daily medication?		
Have you had chemotherapy for cancer?		
Have you ever had radiation to your neck or throat?		
Have you ever had a tracheostomy (an incision in windpipe for breathing)?		
Do you have trouble opening your mouth or looking up at the ceiling?		
Have you traveled outside of the US in the last two months? Where?		
Have you ever had a blood transfusion?		
Would you accept a blood transfusion if necessary?		
Have you been diagnosed with a bleeding disorder?		
Do you have problems with excessive bleeding after surgical or dental procedures?		
If you are a woman of childbearing age, are you or do you believe you may be pregnant?		
 If 1 or more of the bold boxes are checked AND the patient is undergoing high or intermediate risk surgery, patient has a baseline EKG. 	it is recomme	nded that the
 If 2 or more of the bold boxes are checked, the patient should also be referred to their PMD/Cardiologist or Admission Testing. 	the Anesthesi	ologist in Pre-
Patient/Representative Signature:/ Date://	Time:	AM/PM