



50705

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

Your E-mail: _____ Preferred Phone: () ____ - ____

Best time to call: _____ May we leave a message (circle one)? Yes / No

Preferred language: _____ Do you need a translator on the day of surgery (circle one)? Yes / No

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: () ____ - ____

Cardiologist (full name): _____ Phone: () ____ - ____

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... ?	How much/often?	How many years?	If applicable, date quit?
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):

Do you have a pacemaker or an internal defibrillator (circle one)? Yes / No Brand? _____ Last check-up? ____ / ____ / ____

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): PICC Broviac Dialysis catheter Fistula Ventricular device

Insulin pump Other: _____

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