Northwestern Medicine®

PATIENT PREOPERATIVE HISTORY

Name _____ DOB _____

Preferred Daytime Phone #_____Preferred Language _____

Planned surgery _____ Today's Date _____

Surgeon _____Primary Care Physician _____PCP Phone #_____

Please list all previous surgeries (and approximate dates)

Please list any allergies to medications, latex, food or other (and your reactions to them)

List all medications (include over-the-counter drugs, inhalers, herbals, supplements and aspirin)

Drug Name Dose and How Often?	Drug Name Dose and How Often?
1.	**7.**
2.	**8.**
3.	**9.**
4.	**10.**
5.	**11.**
6.	**12.**

Weight: (lbs or kg) _____ Height: (inches or cm) _____ (Circle the measurement units you use)

Please check any of the following that apply to your health:

☐ **Heart attack at any time***	☐ **Heart stent at any time***	☐ **LVAD***
☐ **Heart attack within past 60 days***	☐ **Atrial fibrillation***	☐ **Heart device***
☐ **Chest pain or pressure with activity***	☐ **Arrhythmia***	☐ **Pacemaker***
☐ **Angina***	☐ **Congenital heart disease***	☐ **Defibrillator***
☐ **Heart failure***	☐ Hypertension	☐ **Fainted in the last year***
☐ **Heart surgery***	☐ **Murmur***	☐ Pain in legs while walking
☐ **Heart stent in the last 6 months***	☐ **Valve disorder***	☐ None of these
☐ **Unable to climb 2 flights of stairs or walking 2 blocks because of chest pain or trouble breathing***		

☐ **Oxygen at home***	☐ **Asthma***	☐ **Pneumonia in last 2 months***	☐ None of these
☐ **Pulmonary hypertension***	☐ **COPD***	☐ **Any problems with your lungs***	
☐ **Trouble breathing at rest or with minimal exertions***		☐ **Severe cough***	

Turn form over to complete 2nd page / see second page

*indicates the need for an in person preoperative evaluation.

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Name _____

☐ Face, arm or leg weakness	☐ **Dementia***	☐ **Spinal cord injury***
☐ **Stroke/TIA within past 3 months***	☐ Parkinson's	☐ **Brain tumor***
☐ Stroke or TIA at any time	☐ **Myasthenia gravis***	☐ **Brain aneurysm or AVM***
☐ Paralysis	☐ **Muscular dystrophy***	☐ **Epilepsy, blackouts or seizures***
☐ Difficulty speaking	☐ **Multiple Sclerosis***	☐ None of these

☐ **Hospitalized in last 30 days***	☐ Hepatitis B/C	☐ **Rheumatoid arthritis***
☐ Diabetes	☐ **Jaundice***	☐ Sjogren's
☐ **Cancer: What type?_____***	☐ **Hyperthyroidism***	☐ **HIV***
☐ **Chemo or radiation last 3 months***	☐ Hypothyroidism	☐ **Use illegal drugs (excl. marijuana)***
☐ **Kidney disease other than stones***	☐ **Adrenal disorder***	☐ **Kidney failure***
☐ **Liver disease***	☐ **Pituitary disorder***	☐ Taking antibiotics for any reason
☐ **Cirrhosis***	☐ **Dialysis***	☐ None of these
☐ **Lupus***	☐ **Scleroderma***	

☐ **Blood thinners or anticoagulants other than aspirin***	☐ **Hemophilia***	☐ **Sickle cell disease***
☐ **Bleeding with surgery or tooth extractions***	☐ **Von Willebrands***	☐ **Anemia***
☐ **Blood transfusion in last 3 months***	☐ **Known bleeding disorder***	☐ Severe nose bleeds
☐ **Blood clots/ Pulmonary embolus***	☐ **Jehovah's Witness / Refusal of blood products***	☐ None of these

☐ **Malignant hyperthermia (in blood relatives or self) with anesthesia***	☐ Dentures
☐ **Severe nausea or vomiting from anesthesia***	☐ Problems opening your mouth
☐ Difficult airway with anesthesia	☐ Loose teeth
	☐ None of the these

☐ **Unintentional weight loss > 10 lbs***	☐ Feel that everything you did was an effort: ____ days in the last week
☐ Difficulty getting out of bed/chair by yourself	☐ **Need assistance with eating or bathing or dressing***
☐ Difficulty making your own meals	☐ Fallen in the last 6 months (___ times)
☐ Your physical abilities limit your daily activities	☐ None of the these
☐ Difficulty doing your own shopping	

☐ Very loud snoring	☐ High blood pressure/ Hypertension	☐ Sleep apnea; Uses CPAP
☐ Tired/fall asleep frequently during the day		☐ None of these
☐ **Observed to stop breathing during sleep***	☐ **Sleep apnea; NO CPAP***	

☐ Cannot speak and/or understand English	☐ Deaf	☐ None of these
☐ Cannot lie flat for 45 min	☐ Blind	
☐ Currently pregnant. Last menstrual period began:_____		
☐ Smoker (current or past) _____ packs/day for _____years. Quit date_____		
☐ Drink alcohol. How much each day? _____beers ____ glasses of wine _____shots of hard alcohol		

Please list any medical illness or medications not noted already:

Revised 11/2017

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