



CHECKLIST FOR PREOPERATIVE CALL & TEACHING

Person Interviewed: Patient Parent Guardian Spouse Nursing facility

	Notified	Not Notified	COMMENTS
1) No solid food after midnight	<input type="checkbox"/>	<input type="checkbox"/>	_____
2) Clear liquids up to _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
3) Comfortable clothing (for eye, arm surgery-open front shirt)	<input type="checkbox"/>	<input type="checkbox"/>	_____
4) Responsible adult to drive patient home	<input type="checkbox"/>	<input type="checkbox"/>	_____
5) No valuables (ie, jewelry)	<input type="checkbox"/>	<input type="checkbox"/>	_____
6) Bring insurance card	<input type="checkbox"/>	<input type="checkbox"/>	_____
7) Remove make-up – especially mascara	<input type="checkbox"/>	<input type="checkbox"/>	_____
8) No contact lens, glass case for glasses	<input type="checkbox"/>	<input type="checkbox"/>	_____
9) Be at center _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
10) Directions to center	<input type="checkbox"/>	<input type="checkbox"/>	_____

MEDICATIONS:

To be taken am of surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bring with patient to Surgery center	<input type="checkbox"/>	<input type="checkbox"/>	_____
If on ASA or related meds			
Consult physician	<input type="checkbox"/>	<input type="checkbox"/>	_____

PATIENTS UNDER 18:

Bring clothing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extra diapers, favorite toys			

PODIATRY, ORTHOPEDIC PATIENTS

Wash extremity well	<input type="checkbox"/>	<input type="checkbox"/>	_____
Remove nail polish/acrylic nails	<input type="checkbox"/>	<input type="checkbox"/>	_____
Please bring crutches			
Knee immobilizers, etc	<input type="checkbox"/>	<input type="checkbox"/>	_____

MEDICATIONS _____

SURGICAL HISTORY: _____ **PHONE # DAY OF SURGERY:** _____
 _____ _____
 _____ **TRAVEL TIME TO CENTER:** _____
 _____ _____

RN Signature _____

ANESTHESIA QUESTIONNAIRE

Name _____ Ht _____ Wt _____ Age _____

Date of Surgery _____ BMI _____

Yes No N/A

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you have any allergies? (Meds/Food) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you had any drug reaction? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Are you pregnant? If patient unaware of pregnancy status patient needs to take home pregnancy test and notify pre-op staff on admission of results. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you have a cough? If yes, do you bring anything up when you cough? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you now or have you ever had asthma? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you have a cold/nasal congestion/hoarseness/sore throat? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you smoke? If yes, how many packs/day? _____ For how many years? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you ever had any difficulties breathing? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you become short of breath walking up two flights of stairs? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you ever short of breath when lying down at night? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. Do you have sleep apnea? If yes, <input type="checkbox"/> bring CPAP with patient <input type="checkbox"/> No home CPAP |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had a heart attack? If yes, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had angina or pain in the chest related to your heart? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have a heart murmur? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you have Mitral Valve Prolapse? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have you ever had an abnormal EKG or chest-xray? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 17. Have you ever had other cardiac testing?
Circle all that apply: Echo cardiogram Heart catheterization Treadmill/Stress Test |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have you ever had high blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you ever had other heart problems not listed? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have you ever had hepatitis? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21. Do you have a hiatal hernia or get heartburn? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 22. Do you use alcohol? If yes, how much? _____ How often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have you ever had a stroke? If yes, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you have an arm or leg that becomes numb or weak? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 25. Do you have frequent headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you ever had seizures, episodes of unconsciousness or fainting? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 27. Do you have diabetes? Average blood sugar? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 28. Do you take insulin? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have you ever had thyroid problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 30. Do you have arthritis? If yes, where? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 31. Do you have back or neck problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 32. Do you have any physical disabilities? If yes, list _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 33. Do you have any mental disabilities? If yes, list _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 34. Have you ever had kidney disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you ever been jaundiced? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 36. Have you taken cortisone/prednisone in the past year? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 37. Have you ever had a blood transfusion? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 38. Have you ever been anemic? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you used aspirin in the past two weeks? If yes, how much? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 40. Have you ever had cancer? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 41. Have you ever taken chemotherapy? If yes, what? _____ |

Yes No N/A

- 42. Do you have any chipped or loose teeth?
- 43. Do you have any dentures, caps, bridgework, or braces? (circle all that apply)
- 44. Have you ever had anesthetic?
- 45. Have you ever had a problem with anesthesia? If yes, what? _____
- 46. Anyone related to you ever had a problem with anesthesia? If yes, what? _____
- 47. Have you ever had jaundice or fever after an anesthetic?
- 48. Have you had broken facial bones, back, jaw, or nose surgery?
- 49. Do you have eye drops or do you have glaucoma?
- 50. Are you wearing contact lenses or false eyelashes?
- 51. Do you have any bleeding or clotting abnormalities?
- 52. Have you ever tested positive for HIV or Tuberculosis?
- 53. Any recreational drug use? If yes, kind? _____
- 54. Neonatal problem
- 55. Sickle cell anemia
- 56. Is there anything else you feel you should tell us regarding your health?

Date _____

Completed by _____ Reviewed by Anesthesiologist _____

Reviewed by Admitting RN _____ Reviewed by Operating RN _____

ONE DAY SURGERY PREOPERATIVE PATIENT EDUCATION	YES	NO	N/A
1. Patient understands what to expect in operating room?			
2. Patient understands what to expect in the recovery room?			
3. Patient understands what to expect after surgery and how to manage pain after surgery?			
4. Patient understands importance of coughing, turning, and deep breathing after surgery?			
5. Patients family understands where to wait while patient is in surgery?			
6. Patient understands what to do if they have questions after surgery?			
7. Patient is aware of how to contact their doctor after discharge?			
8. Patient understands surgical prep? (if ordered)			
9. Patient understands reasons for removing dentures, glasses, jewelry, etc?			
10. Patient understands IV would be started?			
11. Patient understands approximate length of procedure, length of time in PACU, and length of time in ODS before discharge?			
12. Patient understands progressive diet after surgery?			
13. Post op instructions for pediatrics			
a. Activity- light activity is permitted; they do not have to stay in bed, however strenuous activity should be avoided			
b. Child must be watched by adult at home			
c. Diet – fluids should be encouraged			
d. Pre-op and post-op needs reviewed with family member and verbalized understanding			
e. Distance from home to a facility which can provide emergency care			
f. Availability of transportation			
DATE: _____ TIME: _____			
Nurses Signature: _____			