**Plastic Surgery Center of the South**

## PRE-OP HEALTH HISTORY

## PATIENT QUESTIONAIRE

This questionnaire will help your doctor determine if any preoperative work up will be needed. For your safety, please fill it out thoroughly and truthfully. Complete information will help to avoid any delay in your surgery.

Today's Date: ___/___/___

| Name | | Phone | Email |
|---|---|---|---|
| Age | Date of Birth | Gender (Assigned at Birth)<br>☐ Male ☐ Female | Gender Identity (If Different)<br>☐ Transgender ☐ Non-binary ☐ Male ☐ Female |
| Height<br>____ ft ____ in (_____ cm) | | Weight<br>_____ lbs (_____ kgs) | (Office Use Only) BMI |
| Primary Care Physician | Phone | Last Visit | Preferred Pharmacy Phone |

| **Heart** | Yes | No | If yes, please elaborate |
|---|---|---|---|
| **1. Have you ever had: (Check all that apply)**<br>☐ Irregular Heartbeat ☐ Heart Valve Problem ☐ Heart Murmur<br>☐ Coronary Artery Disease ☐ Angina ☐ Heart Attack ☐ Afib | | | Do you have a Cardiologist?<br>Name _____<br>Phone _____ |
| **2.** Have you ever had chest pain or shortness of breath after climbing 2 flights of stairs or walking ½ a mile? | | | Describe |
| **3. Have you ever had:**<br>☐ Stress Test ☐ Angiogram ☐ Cardiac Ablation<br>☐ Echocardiogram (Heart Ultrasound) | | | When? _____<br>Where? _____<br>Results? _____ |
| **4. Do you have:**<br>☐ Pacemaker ☐ Defibrillator (ICD) ☐ Stents ☐ Artificial Heart Valve | | | When? |
| **5.** Do you take aspirin or blood thinners? | | | |
| **6.** Do you have or have you had high blood pressure? | | | When were you diagnosed? _____<br>Do you take medication regularly?<br>☐ Yes ☐ No |
| **7.** Do you have varicose veins? | | | Where? |
| **Lungs** | Yes | No | If yes, please elaborate |
| **1. Do you have:**<br>☐ COPD (Emphysema/Chronic Bronchitis)<br>☐ Chronic Asthma ☐ Seasonal Asthma ☐ Exercise Induced Asthma | | | Do you have a Pulmonologist?<br>Name _____<br>Phone _____<br>Last Visit _____ |
| **2.** Have respiratory inhalers ever been prescribed for you? | | | Maintenance inhaler? _____<br>Do you use regularly? _____<br>Rescue inhaler? _____<br>How often do you use? _____ |
| **3.** Have you been to urgent care or a hospital for respiratory symptoms in the last 2 months? | | | What treatments were prescribed? |
| **4.** Have you tested positive for Covid in the last 3 months? | | | Symptoms _____<br>Treatment _____ |
| **5.** Are you currently a smoker?<br>☐ Cigarettes ☐ Vape ☐ Cigars ☐ Pipes ☐ Marijuana ☐ Hookah | | | Number per day |
| **6.** Have you ever been smoker? | | | Number per day _____ Years Smoked _____<br>When did you stop? _____ |
| **7.** Do you have obstructive sleep apnea? | | | When were you diagnosed? _____<br>Were you prescribed: ☐ CPAP ☐ BIPAP<br>Do you use it regularly? _____ |
| **8.** Do you snore loudly enough to be heard through closed doors? | | | |
| **9.** Has anybody observed you stop breathing or choking/gasping during your sleep? | | | |

| | | | |
|---|---|---|---|
| **10.** Do you often feel fatigued or sleepy during the day? | | | |
| **11.** Is your neck circumference greater than 16 inches? | | | |
| **Brain/Neuro** | Yes | No | If yes, please elaborate |
| **1.** Have you ever had a stroke or TIA (mini stroke)? | | | When? _____<br>Residual Effects? _____ |
| **2.** Have you ever had epilepsy or seizures? | | | Last episode: _____ |
| **3.** Do you have significant memory problems or dementia? | | | |
| **4. Do you have a Neuromuscular Disorder:**<br>☐ Muscular Dystrophy ☐ Myasthenia Gravis ☐ ALS ☐ Parkinson's<br>☐ Other | | | Do you have a Neurologist?<br>Name _____<br>Phone _____<br>Last Visit _____ |
| **Blood** | Yes | No | If yes, please elaborate |
| **1.** Do you have any type of anemia (low blood count)?<br>☐ Iron Deficiency ☐ Sickle Cell ☐ Thalassemia ☐ Pernicious | | | Do you have a Hematologist?<br>Name _____<br>Phone _____ |
| **2.** Have you had a blood transfusion or an iron infusion? | | | When? |
| **3.** Do you have a bleeding or clotting disorder? | | | Specify |
| **4.** Have you ever had a blood clot? (In your lungs, legs, or other) | | | When? |
| **5.** Do you have any family (blood relatives) who have had a blood clot? | | | Who? |
| **Other Important Medical Information** | Yes | No | If yes, please elaborate |
| **1.** Do you have diabetes? ☐ Type 1 ☐ Type 2 | | | Treatment: ☐ Insulin ☐ Diabetic Pills ☐ Diet<br>Most recent A1C result: _____ |
| **2.** Do you have thyroid disease? ☐ Overactive ☐ Underactive | | | |
| **3.** Do you have any stomach issues?<br>☐ Acid Reflux ☐ Ulcers ☐ Hiatal Hernia ☐ Slow Emptying<br>☐ Gastric Bypass ☐ Gastric Sleeve | | | |
| **4.** Do you have inflammatory bowel disease?<br>☐ Chron's ☐ Ulcerative Colitis ☐ Irritable Bowel Syndrome | | | |
| **5.** Do you have an autoimmune disease?<br>☐ Rheumatoid Arthritis ☐ Lupus ☐ Scleroderma<br>☐ Multiple Sclerosis ☐ Other | | | |
| **6.** Have you ever had cancer of any kind? | | | Specify<br>Treatment: ☐ Chemo ☐ Surgery ☐ Radiation |
| **7.** Have you ever had kidney disease? | | | Describe |
| **8.** Have you ever had liver problems such as hepatitis or cirrhosis? | | | |
| **9.** Have you been treated with steroids in the last 6 months? | | | Describe |
| **10.** Have you ever had MRSA (antibiotic resistant infection)? | | | When |
| **11.** Are you being treated for chronic pain? | | | Describe |
| **12. Are you being treated for:**<br>☐ Anxiety ☐ Depression ☐ Bipolar Disease ☐ PTSD<br>☐ ADD/ADHD ☐ Schizophrenia ☐ Substance Addiction | | | |
| **13.** Do you have a history of genital or oral Herpes? | | | |
| **Female Patients** | Yes | No | If yes, please elaborate |
| **1.** Is there a possibility that you could be pregnant? | | | |
| **2.** Have you ever been pregnant? | | | How many pregnancies? _____<br>How many births? _____ |
| **3.** Have you ever had miscarriages? | | | How many? _____ |
| **4.** Do you use a form of birth control that contains hormones? | | | |
| **Social Habits/Lifestyle** | Yes | No | If yes, please elaborate |
| **1.** Do you exercise? | | | ☐ Occasionally ☐ Regularly ☐ Daily |
| **2.** Do you drink alcohol? | | | ☐ Occasionally ☐ Regularly ☐ Daily |
| **3.** Do you use nicotine products? ☐ Cigarettes ☐ Gum ☐ Patch ☐ Vape | | | ☐ Occasionally ☐ Regularly ☐ Daily |
| **4.** Do you use recreational drugs?<br>☐ Cannabis/THC ☐ Cocaine ☐ MDMA/Ecstasy<br>☐ Heroin ☐ Hallucinogens ☐ Methamphetamines | | | ☐ Occasionally ☐ Regularly ☐ Daily |
| **5.** Do you take herbal or homeopathic suppliments? | | | Please include in your medication list later |
| **6.** Do you use weightloss medications?<br>(Phentermine, Qsymia, Contrave, Xenical, GLP-1 Injections, etc.) | | | Please include in your medication list later |

| | | | |
|---|---|---|---|
| **7.** Do you use sedatives? (Valium, Xanax, Ativan, Klonopin, etc.) | | | Please include in your medication list later |
| **8.** Do you use sleeping aids? (Trazadone, Restoril, Lunesta, Ambien, Cymbalta, etc.) | | | Please include in your medication list later |
| **9.** Do you use medications for mental focus? (Ritalin, Adderall, Vyvanse, Concerta, etc.) | | | Please include in your medication list later |
| **10. Do you take hormones?** | | | Please include in your medication list later |
| **11.** Do you wear contact lenses? | | | |
| **12.** Do you wear hearing aids? | | | |
| **13. Do you wear any of the following:** ☐ False Eyelashes ☐ Acrylic Nails ☐ Wig/Weave ☐ Body Jewelry | | | |
| **Dental/Airway** | Yes | No | If yes, please elaborate |
| **1. Do you have any of the following:** ☐ Caps ☐ Crowns ☐ Veneers ☐ Implants ☐ Dentures ☐ Partial Plate ☐ Bridges ☐ Braces | | | |
| **2. Are any of your teeth:** ☐ Loose ☐ Chipped ☐ Broken ☐ Cracked | | | Where? |
| **3.** Do you have any trouble opening your mouth or moving your neck? ☐ TMJ Disorder ☐ Poor Jaw Mobility ☐ Cervical Fusion | | | |
| **Anesthesia History** | Yes | No | If yes, please elaborate |
| **1.** Have you ever had anesthesia? ☐ General Anesthesia ☐ Spinal/Epidural ☐ Nerve Block ☐ Sedation | | | |
| **2.** Have you had any problems with anesthesia? ☐ Malignant Hyperthermia ☐ Pseudocholinesterase Deficiency ☐ Nausea/Vomiting ☐ Difficulty With Insertion of the Breathing Tube ☐ Prolonged Confusion After Anesthesia ☐ Other | | | Specify |
| **3.** Do you have any family (blood relatives) who have had problems with anesthesia? ☐ Malignant Hyperthermia ☐ Pseudocholinesterase Deficiency ☐ Other | | | Specify |

**List Any Surgeries You Have Had in the Past**

| Procedure | Year | Procedure | Year |
|---|---|---|---|
| **1.** | | **6.** | |
| **2.** | | **7.** | |
| **3.** | | **8.** | |
| **4.** | | **9.** | |
| **5.** | | **10.** | |

**List ALL of the Medications That You Take (Including Herbal Medication, Vitamins, and Non-Prescription Drugs)**

| | |
|---|---|
| **1.** | **8.** |
| **2.** | **9.** |
| **3.** | **10.** |
| **4.** | **11.** |
| **5.** | **12.** |
| **6.** | **13.** |
| **7.** | **14.** |

**List ALL Medication Allergies**

| Medication | Reaction |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |
| **4.** | |
| **5.** | |

| **Allergies** | Yes | No | If yes, please elaborate |
|---|---|---|---|
| 1. Are you allergic to latex? | | | Describe Reaction |
| 2. Have you been tested for latex allergy? | | | When? _____<br>Results? _____ |
| **3. Are you allergic to any of the folowing:**<br>☐ Adhesives ☐ Avacado ☐ Banana ☐ Chestnut<br>☐ Kiwi ☐ Eggs ☐ Soybeans | | | Describe Reaction |
| **Discharge Planning** | Yes | No | If yes, please elaborate |
| 1. When discharged, do you have a responsible adult to drive you home following your surgery? | | | Name _____<br>Phone _____ |
| 2. When you leave surgery, is your trip longer than 30 minutes? | | | Length of Trip _____ |
| 3. Do you have someone available to stay with you overnight and help care for you? | | | Name _____<br>Phone _____ |
| 4. Are you interested in private post-operative care in your home? | | | Do you need help finding someone? _____ |
| 5. Do you have stairs to climb when you are at home? | | | |
| 6. Do you plan to travel within 14 days after your surgery? | | | By: ☐ Car ☐ Plane<br>How many hours of travel? _____ |

**Do you have any other illnesses, limitaions, or concerns that we should know about?** ☐ Yes ☐ No
Specify:

## For Pre-Operative Unit Use ONLY

| History Reviewed By...(Signature) | Required Follow Up | Notes Regarding Follow Up |
|---|---|---|
| Pre op RN _____ | ☐ EKG | _____ |
| | ☐ Cardiac Clearance | _____ |
| Anesthesia _____ | ☐ Medical Clearance | _____ |
| | ☐ Labs | _____ |
| Surgeon _____ | ☐ BP Check | _____ |
| | ☐ Weight Check | _____ |
| | ☐ Airway Exam | _____ |
| **DVT Score** _____ | ☐ Respiratory Exam | _____ |
| **Xarelto?** _____ | ☐ Other: _____ | _____ |

**Final Approval** _____ **Initials** _____ **Date** _____

**Denied** _____ **Initials** _____ **Date** _____ **Reasons** _____