NYU Langone MEDICAL CENTER

Patient Name:_____

Medical Record Number:_____

# NYU Hospitals Center

## Pre-Admission Testing Patient Screening Questionnaire

| | |
|---|---|
| **Patient Name:** | **Date of Birth:** |
| **Primary Care Provider Dr.:**<br>**Phone:** | **Cardiologist/Specialist Dr.:**<br>**Phone:** |
| **Diagnosis:**<br>**Surgical Procedure:** | **Surgeon:**<br>**Phone** |
| **METS Score** (nurses use only): Wheelchair bound? Bedridden? | Height: Weight: |

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Do you have or are you being treated for high blood pressure? *If yes, how many years?* | ☐ | ☐ | Have you ever had a heart valve replacement or repair? |
| ☐ | ☐ | Do you have chest pain with walking/normal activity? With exercise? | ☐ | ☐ | Do you have a pacemaker or defibrillator? |
| ☐ | ☐ | Have you ever had a coronary bypass or angioplasty? | ☐ | ☐ | Have you ever been told that you have a widening of your aorta or that you have an aortic aneurysm? |
| ☐ | ☐ | Have you ever had a heart attack?<br>*If yes, how many?: When?:* | ☐ | ☐ | Have you ever been told you have peripheral vascular disease? |
| ☐ | ☐ | Do you have a heart stent?<br>*If yes, how many?: When?:* | ☐ | ☐ | Have you ever had a stress test?<br>*If yes, where?: When?:* |
| ☐ | ☐ | Do you have a weak or failing heart (congestive heart failure, CHF)? | ☐ | ☐ | Have you ever had a cardiac echo test?<br>*If yes, where?: When?:* |
| ☐ | ☐ | Do you have an irregular heartbeat or heart rhythm? | ☐ | ☐ | Have you ever had a heart catheterization?<br>*If yes, where?: When?:* |
| ☐ | ☐ | Do you have a heart murmur or mitral valve prolapse? | | | |
| ☐ | ☐ | Do you take daily medication for asthma? | ☐ | ☐ | Do you have difficulty breathing (do you wheeze)? |
| ☐ | ☐ | Do you have a history of chronic bronchitis or emphysema (COPD-Chronic Obstructive Pulmonary Disease)? | ☐ | ☐ | Do you use supplemental oxygen? |
| ☐ | ☐ | Do you smoke? *If yes, how many packs / day?:*<br>*How may years have you been a smoker?:* | ☐ | ☐ | Do you have a history of sleep apnea? CPAP-Continuous Positive Airway Pressure? |
| ☐ | ☐ | Have you had any recent colds, fever or flu symptoms? | ☐ | ☐ | Have you ever been witnessed to stop breathing while asleep? |
| ☐ | ☐ | Do you have diabetes? *If yes, for how many years?: Complications?:* | ☐ | ☐ | Do you take insulin? |
| ☐ | ☐ | Do you have kidney problems (other than kidney stones)? | ☐ | ☐ | Have you ever had Hepatitis A / B / C / D? (circle) |
| ☐ | ☐ | Do you have liver problems? | | | |
| ☐ | ☐ | Do you drink alcohol every day?<br>*If yes, how many drinks/day?:* | ☐ | ☐ | Do you use recreational drugs?<br>*If yes, specify:* |

***Please Turn Over To Continue***

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## Pre-Admission Testing Patient Screening Questionnaire

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Do you have a history of anemia? | ☐ | ☐ | Do you have a history of sickle cell disease or trait? |
| ☐ | ☐ | Do you take any blood thinners (e.g. Coumadin)? | ☐ | ☐ | Do you have a history of cancer? |
| ☐ | ☐ | Do you take Aspirin or Ibuprofen regularly? | ☐ | ☐ | Are you on Chemo Therapy? |
| ☐ | ☐ | Do you have seizures or take anti-seizure medications? | ☐ | ☐ | Do you have neuromuscular disease (including Parkinson's, ALS etc)? |
| ☐ | ☐ | Have you ever had a stroke(CVA), mini stroke(TIA) or brain attack? *If yes, when?:* | ☐ | ☐ | Do you have a brain tumor, brain aneurysm or other vascular lesion of the brain? |
| ☐ | ☐ | Have you been told that it is difficult to place a breathing tube in your airway (intubate)? | ☐ | ☐ | Do you have a history of severe reaction to anesthesia? |
| ☐ | ☐ | Do you or a family member have a history of high fever after anesthesia (malignant hyperthermia)? | ☐ | ☐ | Do you suffer from chronic pain? |
| ☐ | ☐ | Do you have a history of severe nausea and vomiting after anesthesia? | ☐ | ☐ | Is there a possibility you could be pregnant? *LMP:* |
| ☐ | ☐ | Do you have an autoimmune disease (e.g. Rheumatoid Arthritis, Sarcoidosis or Lupus)? | ☐ | ☐ | Do you have any other medical problems that we have not asked you about? *If yes, specify:* |
| *OFFICE USE: EKG results good for 6 months. Chemistry lab results good for 3 months* | | | | | |

Please list the medications you currently take and the dose.

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____