



Rhode Island Hospital

A Lifespan Partner

Adult Perioperative Assessment Data

Please complete form and bring with you on day of surgery OR day of scheduled pre-surgical visit.

Name _____ Age _____

How do you wish to be addressed _____ Height _____

Weight _____

Family Physician _____ Family MD Phone # _____ Last Visit _____

Planned Procedure _____

Surgeon _____ Please circle surgery side (if applicable) **Right** **Left** **Both**

Please List all medications you take and the doses. (Include any prescription and non-prescription drugs.)

Medication	Dose	Times/Day	Medication	Dose	Times/Day

Please answer the following:

	Yes	No		Yes	No
Do you have any allergies? (list on back)			Have you ever had kidney disease?		
Have you or a family member ever had a problem with local or general anesthesia?			Have you ever had a problem with your prostate?		
Have you ever had any heart trouble?			Have you ever been on dialysis?		
Murmurs: Irregular heartbeat					
Congestive Heart Failure			Do you have stomach ulcers?		
Did you ever have a heart attack?			Hiatal Hernia		
Do you have angina?			Esophageal Reflux		
Have you ever had a stress test?			Have you had a recent weight gain or Weight loss?		
Have you ever had a cardiac catheterization?			Do you have thyroid disease?		
Do you get short of breath after climbing a flight of stairs?			Have you ever had a seizure?		
Do you have any lung disease?			Have you ever had a stroke or mini stroke?		
Asthma					
Emphysema			Do you have frequent headaches?		
Tuberculosis			Migraine headaches		
Chronic cough					
Have you ever had an abnormal chest x-ray?			Do you have diabetes?		
Do you have high blood pressure?					
Have you ever been treated for high blood pressure?			Do you have back or neck problems?		
			Do you have any bleeding abnormalities?		
Have you ever had any Liver Disease?			Have you ever had a blood transfusion?		
Hepatitis			Do you have Sickle Cell Anemia?		
Jaundice					
Cirrhosis			Are you HIV Positive?		
			Do you smoke?		
	Yes	No		Yes	No
Have you had recent exposure to measles, mumps,			Did you ever smoke?		

or chicken pox?			Pack per day	Quit		
Is your immunization record up to date?			Do you drink alcoholic beverages? How much?	Day	Week	
Could you be pregnant?			Have you ever used intravenous drugs?			
Do you wear glasses? Contact lenses			Do you use: Wheelchair Cane or walker			
Do you have dentures? Bridgework Capped Teeth Loose Teeth			Hearing Aides	Left	Right	
			Oxygen Therapy			
			CPAP			
			Any other medical devices			

Please list the major illnesses that you have had:

Please list any allergies or reactions you may have to medications, food, IV, CAT scan dye, latex, rubber gloves or elastic. Describe the reaction:

Please list any surgeries you have had in the past and approximately the year they were done.

Do you have any religious or cultural customs that would affect your care? _____

Do you speak English? _____ Language spoken: _____

Do you live alone? _____ Who will help you at home after discharge? _____

I certify that the information on the questionnaire is correct to the best of my knowledge.

_____ Date _____
(Patient or Parent of Minor)

=====

Hospital Use Only

- SDA/PAT Pre Op instructions given _____
- SDA/PAT Data Review @ PSE _____
- Additional remarks _____

Assessment Form Reviewed by: _____
 (Print Name/Signature) (Date)

 (Print Name/Signature) (Date)