

## Nursing Preoperative Screening

This sample form may be use for nursing preadmission before the day of surgery. This form may be used for telephone or in-person screening and modified per facility policy and procedure.

Patient Identification No: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

Latex Sensitivity       yes       no

Advance Directive       yes       no

Food List       yes       no

Language Spoken (if other than English): \_\_\_\_\_

Planned Surgical Procedure: \_\_\_\_\_

### Medical History Screening

(check and/or comment on all that apply)

### Comment

#### Cardiovascular

- Angina
- Arrhythmia
- Congestive heart failure
- Hypertension
- Myocardial infarction
- Pacemaker
- AICD (automatic implantable cardioverter defibrillator)
- Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Respiratory

- Asthma
- COPD (chronic obstructive pulmonary disease)
- Emphysema
- Obstructive sleep apnea
- CPAP (continuous positive airway pressure)
- Recent cold/flu
- Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Hematologic

- Anemia
- Bleeding tendency
- Blood transfusions
- Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Gastrointestinal

- Problems chewing/swallowing
- Gastroesophageal reflux disease
- Hiatal hernia
- Peptic ulcer disease
- Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Continued . . .

## Medical History Screening

### Neuromuscular/Musculoskeletal

- Arthritis
- Back/neck problems
- Seizures
- Amputation/prosthesis
- Other: \_\_\_\_\_

### Comment

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### Miscellaneous

- Diabetes
- Stroke
- Liver disease
- Kidney disease
- Pregnancy
- Last menstrual period
- Communicable disease
- Patient
- Family member

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### Prior Health Habits (indicate frequency in comments)

- Alcohol \_\_\_\_\_
- Caffeine \_\_\_\_\_
- Recreational drugs \_\_\_\_\_
- Tobacco \_\_\_\_\_

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### Arriving via

- Ambulatory
- Wheelchair
- Stretcher
- Other assistive devices: \_\_\_\_\_

### Individual who will escort patient home

Name: \_\_\_\_\_  
 Phone number: \_\_\_\_\_  
 Relationship: \_\_\_\_\_

### Sensory Assessment

- No limitations
- Hearing impairment
- Visual impairment

### Comment

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### Does the patient have any of the following:

- Dentures
- Hearing aid(s)
- Contact lenses

### Comment

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Continued . . .

**Previous Surgeries or Procedures (describe as applicable)**

\_\_\_\_\_

\_\_\_\_\_

**Anesthesia History**

	Yes	No	Don't know	Comments
Never had anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patient/family history of problem with anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patient/family history of malignant hyperthermia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loose teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Caps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Current Medication History (list all that apply, including herbal supplements and over-the-counter medications)**

Medication	Dose	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current pharmacy: \_\_\_\_\_

Information obtained from:     Patient     Spouse     Parent     Other: \_\_\_\_\_

Nurse completing form: \_\_\_\_\_

Nurse's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For more information, go to <http://www.patientsafetyauthority.org>.**  
**This form accompanies the following:**  
**Patient screening and assessment in ambulatory surgical facilities.**  
***Pa Patient Saf Advis***  
**2009 Mar;6(1):3-9.**

References

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