INOVA

barcode: 2PSMHX

Patient Name: _____ Date of Birth: _____

Patient Preferred Daytime Phone #: _____ Today's Date: _____

Planned Surgery: _____

Surgeon (print name): _____

Patient Weight: _____ ☐ pounds ☐ kilograms Patient Height: _____ ☐ inches ☐ centimeters

**List your physicians, their specialty, and phone number:**

| Physician | Specialty | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**List your current medications** (include over-the-counter medications, prescriptions, vitamins, and electrolytes)**:**

| Medication | Dose | Frequency |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| **If more space is needed, please use the back of the form.** | | |

**List any allergies to medications, foods, or metals:**

| | | |
|---|---|---|
| 1. | 4. | 7. |
| 2. | 5. | 8. |
| 3. | 6. | 9. |

**List previous procedures and surgeries requiring anesthesia:**

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

PATIENT IDENTIFICATION – **INOVA STAFF TO COMPLETE**

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

**Inova**

Patient Preoperative History

**Inova Staff to Complete:**

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH



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**Check any of the following that apply to your health:**
*An in-person preoperative evaluation is recommended for patients with these conditions.

- ☐ 1. Angina*
- ☐ 2. Arrhythmia*
- ☐ 3. Atrial fibrillation*
- ☐ 4. Chest pain or pressure with activity*
- ☐ 5. Congenital heart disease*
- ☐ 6. Defibrillator*
- ☐ 7. Fainted in last year*
- ☐ 8. Heart attack at any time*
- ☐ 9. Heart attack within past 60 days*
- ☐ 10. Heart device*
- ☐ 11. Heart failure*
- ☐ 12. Heart stent within past 6 months*
- ☐ 13. Heart stent at any time*
- ☐ 14. Heart surgery*
- ☐ 15. Hypertension
- ☐ 16. Left ventricular assist device (LVAD)*
- ☐ 17. Murmur*
- ☐ 18. Pacemaker*
- ☐ 19. Pain in legs while walking
- ☐ 20. Unable to climb 2 flights of stairs or walk 2 blocks because of chest pain or trouble breathing*
- ☐ 21. Valve disorder*
- ☐ 22. None of these

- ☐ 23. Any problems with your lungs*
- ☐ 24. Asthma*
- ☐ 25. Chronic obstructive pulmonary disease (COPD)*
- ☐ 26. Oxygen at home*
- ☐ 27. Pneumonia in past 2 months*
- ☐ 28. Pulmonary hypertension*
- ☐ 29. Severe cough*
- ☐ 30. Trouble breathing at rest or with minimal exertion*
- ☐ 31. None of these

- ☐ 32. Brain aneurysm or arteriovenous malformation (AVM)*
- ☐ 33. Brain tumor*
- ☐ 34. Dementia*
- ☐ 35. Difficulty speaking
- ☐ 36. Epilepsy, blackouts, or seizures*
- ☐ 37. Face, arm, or leg weakness
- ☐ 38. Multiple sclerosis*
- ☐ 39. Muscular dystrophy*
- ☐ 40. Myasthenia gravis*
- ☐ 41. Paralysis
- ☐ 42. Parkinson's
- ☐ 43. Spinal cord injury*
- ☐ 44. Stroke/Transient ischemic attack (TIA) within past 3 months*
- ☐ 45. Stroke or TIA at any time
- ☐ 46. None of these

- ☐ 47. Adrenal disorder*
- ☐ 48. Cancer (Type: _____)*
- ☐ 49. Cirrhosis*
- ☐ 50. Chemo or radiation in past 3 months*
- ☐ 51. Diabetes – circle which type: Type 1* Type 2
- ☐ 52. Dialysis* - circle which day(s): Mon Tue Wed Thu Fri Sat Sun
- ☐ 53. Hepatitis B/Hepatitis C
- ☐ 54. Hospitalized in past 30 days*
- ☐ 55. Human Immunodeficiency Virus (HIV)*
- ☐ 56. Hyperthyroidism*
- ☐ 57. Hypothyroidism
- ☐ 58. Jaundice*
- ☐ 59. Kidney disease other than stones*
- ☐ 60. Kidney failure*
- ☐ 61. Liver disease*
- ☐ 62. Lupus*
- ☐ 63. Pituitary disorder*
- ☐ 64. Rheumatoid arthritis*
- ☐ 65. Scleroderma*
- ☐ 66. Sjogren's*
- ☐ 67. Taking antibiotics for any reason
- ☐ 68. Use of illegal drugs (excluding marijuana)*
- ☐ 69. None of these

- ☐ 70. Anemia*
- ☐ 71. Bleeding with surgery or tooth extraction*
- ☐ 72. Blood clots/pulmonary embolus*
- ☐ 73. Blood transfusion in past 3 months*
- ☐ 74. Blood thinners or Anticoagulants other than aspirin*
- ☐ 75. Hemophilia*
- ☐ 76. Jehovah's Witness/Refusal of blood products*
- ☐ 77. Known bleeding disorder*
- ☐ 78. Sickle cell disease*
- ☐ 79. Severe nose bleeds
- ☐ 80. Von Willebrand*
- ☐ 81. None of these

- ☐ 82. Dentures
- ☐ 83 Difficult airway with anesthesia
- ☐ 84. Loose teeth
- ☐ 85. Malignant hyperthermia (in blood relatives or self) with anesthesia*
- ☐ 86. Problems opening your mouth
- ☐ 87. Severe nausea or vomiting from anesthesia
- ☐ 88. None of these

- ☐ 89. Difficulty doing your own shopping
- ☐ 90. Difficulty getting out of bed/chair by yourself
- ☐ 91. Difficulty making your own meals
- ☐ 92. Fallen in past 6 months (__times)
- ☐ 93. Feel that everything you did was an effort (___ days in past week)
- ☐ 94. Need assistance with eating, bathing, or dressing*
- ☐ 95. Unintentional weight loss greater than 10 pounds*
- ☐ 96. Your physical abilities limit your daily activities
- ☐ 97. None of these

PATIENT IDENTIFICATION – **INOVA STAFF TO COMPLETE**

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

**Inova**

Patient Preoperative History



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INOVA

barcode: 2PSMHX

**Check any of the following that apply to your health** (continued)**:**
*An in-person preoperative evaluation is recommended for patients with these conditions.

☐ 98. High blood pressure/hypertension
☐ 99. Observed to stop breathing during sleep*
☐ 100. Sleep apnea – uses continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP)
☐ 101. Sleep apnea – NO CPAP or BiPAP*
☐ 102. Tired/fall asleep frequently during the day
☐ 103. Very loud snoring
☐ 104. None of these

☐ 105. Blind
☐ 106. Cannot lie flat for 45 minutes
☐ 107. Cannot speak/understand English
☐ 108. Currently pregnant – Last menstrual period began: _____
☐ 109. Deaf
☐ 110. Drink alcohol - Each day:
____ beers
____ glasses of wine
____ shots of hard alcohol
☐ 111. Smoker (current/past) –
Usage: _____ packs/day
for _____ years
Date quit: _____
☐ 112. None of these

Please list any medical illness or medications not noted already: _____

_____

_____

_____

_____

_____

My signature verifies that the information provided is correct to the best of my knowledge.

_____ _____ _____
**Patient or Designated Decision Maker** (signature) Date Time

_____ _____
**If Designated Decision Maker** (print name) Relationship

**Reviewed by Physician** (signature): _____ Date: _____ Time: _____

**Physician** (print name): _____

**Interpreter Information** (To be completed by Inova staff, if applicable)**:**
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION – **INOVA STAFF TO COMPLETE**

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

**Inova**

Patient Preoperative History



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