Cooperman Barnabas Medical Center | RWJBarnabas HEALTH

Pre-Admission Evaluation Clinic
Patient Questionnaire

Date:_____

Patient Name:	**Date of Birth:**	
Cell Phone #: **Home Phone #:**	**Height:**	**Weight:**

Procedure:	**Date of Procedure:**
Surgeon: **Phone #:** **Fax #:**	
PCP (Primary Care): **Phone #:** **Fax #:**	**Do you have an appt for medical clearance?** ○ Yes, when? ○ No

Do you see a medical specialist?	○ Yes, complete below.	○ No
Cardiologist (Heart Doctor): Name **Phone #:** **Fax #:**	**Do you have an appt for cardiac clearance?** ○ Yes, when? ○ No	
Pulmonologist (Lung Doctor): Name **Phone #:**		
Other Specialist: Name **Phone #:**		
Other Specialist: Name **Phone #:**		

Would you ***ACCEPT*** a blood transfusion to save your life?	○ Yes	○ No why? ○ Religious ○ Personal
Have you ever had a blood transfusion?	○ Yes, when?	○ No
Have you been pregnant during the previous 3 months?	○ Yes	○ No ○ N/A
Do you have **Autologous** (your own) or **Directed** Units of Blood (from family or friend) available for this procedure?	○ Yes	○ No
Do you take Blood Thinners (Brillinta, Coumadin, Eliquis, Plavix, Pradaxa, etc.)?	○ Yes	○ No
Do you take Aspirin or NSAIDs/Anti-Inflammatories (Advil, Aleve, Ibuprofen, Motrin, Naproxen, etc.) regularly?	○ Yes	○ No

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List all **PRESCRIPTION MEDICATIONS** you take. Include dose and frequency.	List all **OVER THE COUNTER MEDICATIONS and/or VITAMINS/HERBAL SUPPLEMENTS** you take. Include dose and frequency.
☐ **NONE**	☐ **NONE**

List all ALLERGIES to medications/food/latex/contrast/dye	**Reaction**	**List all ALLERGIES to medications/food/latex/contrast/dye**	**Reaction**
☐ **NONE**			

List all SURGERIES/PROCEDURES	**Date**	**List all SURGERIES/PROCEDURES**	**Date**
☐ **NONE**			

In the last 2 weeks, what activity level can you do the most ***without*** chest pain or shortness of breath?
Check one box only.

☐ **LIGHT INTENSITY ACTIVITIES**
- **Getting dressed**
- **Walk around the house**
- **Walk slow pace, level ground**

☐ **MEDIUM INTENSITY ACTIVITIES**
- **Climb 2 flights of stairs**
- **House work, cleaning, sweeping**
- **Yard work, moderate effort**
- **Biking for pleasure, light effort**
- **Swimming laps leisurely**
- **Walk moderate-fast pace, level ground, several miles**

☐ **VIGOROUS INTENSITY ACTIVTIES**
- **Climb 3 flights of stairs quickly**
- **Walk brisk pace, several miles**
- **Biking vigorously**
- **Heavy lifting**
- **Run several miles**

☐ **Cannot perform activities due to back and/joint pain or a medical condition. Please explain:**
☐ **Use of cane, crutches, walker, wheelchair, etc.**

Any nausea/vomit after anesthesia?	○Yes	○No
Have you or any family ever had a severe reaction to anesthesia?	○Yes	○No
Ever been a "difficult intubation" or it was hard to place a breathing tube in your throat?	○Yes	○No
Do you get motion sickness?	○Yes	○No
History of Heart Attack	○Yes, when?	○No
Coronary Artery Bypass or Stent	○Yes, when?	○No
Valve Problems or Valve Surgery	○Yes	○No
Pacemaker or Defibrillator	○Yes	○No
History of Congestive Heart Failure (CHF)	○Yes	○No
High Blood Pressure	○Yes	○No
Irregular or Abnormal Heartbeat	○Yes	○No
Ever get ***chest pain, tightness, or pressure*** with activity (walking, running, climbing stairs, lifting something heavy)?	○Yes	○No
Ever had an echo (ultrasound) of the heart or a stress test?	○Yes when?	○No
Asthma or Chronic Obstructive Pulmonary Disease (COPD)	○Yes	○No
Sleep Apnea Do you use a CPAP Machine? *If yes, bring your machine on day of surgery.*	○Yes	○No
Do you snore?	○Yes	○No
Do you have daytime sleepiness?	○Yes	○No
Diabetes	○Yes	○No
Do you take insulin?	○Yes	○No
Do you check your blood sugar every day?	○Yes	○No
Is your blood sugar reading over 200 in the morning?	○Yes	○No
Kidney Disease	○Yes	○No
Are you on Dialysis?	○Yes	○No
History of Anemia or Low Blood Count	○Yes	○No
Sickle Cell Disease/Trait/Thalassemia	○Yes	○No
History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.)	○Yes	○No
Bleed or bruise easily?	○Yes	○No
Blood Clots	○Yes	○No
History of Cancer? What type/location?	○Yes	○No
Currently on Chemotherapy or Radiation	○Yes	○No
Liver Disease or History of Hepatitis	○Yes	○No
Any Ulcers, Reflux, or Heartburn?	○Yes	○No

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History of Stroke (CVA) or Mini Stroke (TIA)	○Yes	○No
Ever fainted or "blacked-out" in the last year	○Yes	○No
Seizures/Epilepsy	○Yes	○No
Depression or Anxiety requiring treatment	○Yes	○No
HIV/AIDS	○Yes	○No
History of COVID Infection?	○Yes, when?	○No
Were you hospitalized?	○Yes	○No
Do you currently smoke or vape? If yes, how many PPD? How often?	○Yes	○No
Do you drink alcohol? If yes, how many drinks? How often?	○Yes	○No
Do you use recreational drug (street drugs)? If yes, what kind? How often?	○Yes	○No
Any unplanned weight loss in the last 6 months? If yes, how much?	○Yes	○No
Have you been eating less than 50% of your normal diet compared to last week?	○Yes	○No
When was your last menstrual period?		○N/A
Are you breastfeeding?	○Yes	○No ○N/A
Have you received the COVID-19 Vaccination(s)/Booster(s)? If yes, how many? _____ When? _____ _____ _____ _____ _____ _____ **Please give copy of your card to staff.*	○Yes	○No
Have you been in close contact (shared living space or in a close physical contact) with a person presumed positive or has tested positive for COVID-19 Infection in the last 14 days?	○Yes	○No
Do you currently have: ○ Fever ○ Chills ○ Cough ○ Sore throat ○ Runny nose/sneezing ○ Headaches ○ New loss of taste or smell ○ Diarrhea ○ Muscle or body aches	○Yes	○No
Do you have any other medical conditions you would like to mention?	○Yes	○No