COLUMBIA UNIVERSITY MEDICAL CENTER

PREOPERATIVE SCREENING TOOL MUST BE PRESENT AT TIME OF BOOKING

(Please print clearly)

Patient to Complete

Patient Name: ____________________ Date of Birth: ____________ Sex: ______

Phone Numbers: 1. ____________________ Secondary Contact: 2. ____________

Email: ____________________ Primary Care Physician: ____________

➢ **Current Primary Complaint(s)** ____________________

➢ **Medical History:** *Please answer following questions:*

Question	Answer	Question	Answer
Do you have sleep apnea, use CPAP OR BiPAP?	☐ N ☐ Y	Do you have a history of liver disease or chronic cirrhosis?	☐ N ☐ Y
Do you become short of breath or develop chest pain when climbing two flights of stairs?	☐ N ☐ Y	In the past two years, have you required prolonged treatment with steroids?	☐ N ☐ Y
Do you have blood pressure that requires three or more medications to manager?	☐ N ☐ Y	Do you have diabetes that requires insulin treatment?	☐ N ☐ Y
Have you ever had blood clots, stroke, carotid artery blockage, or TIAs (mini strokes)?	☐ N ☐ Y	Do you have problems with excessive bleeding after surgical or dental procedures?	☐ N ☐ Y
Are you currently taking blood thinners, such as Coumadin, Plavix, etc.?	☐ N ☐ Y	Are you, or do you believe you might be pregnant?	☐ N ☐ Y
Do you have Kidney problems (except for Kidney Stones or recurrent infections) that require treatment by a kidney specialist or are you on dialysis?			☐ N ☐ Y

➢ **Implantable Device(s):** ☐ No ☐ Yes, *Indicate type of device(s):*

☐ Pacemaker/Defibrillator	☐ Cardiac Stent	☐ Ventricular Assist Device	☐ Insulin Pump	☐ Other:
Year:	Year: :	Year:	Year:	

➢ **Surgical History:** ☐ No ☐ Yes, *List surgeries:*

Year	Type of Surgery/Procedure	Describe any Anesthesia Complication *(other than nausea or vomiting):*

➢ **Social History** *(Please check)* smoking, alcohol, drug use *(Other please specify)*

☐ Smoking	☐ Alcohol	☐ Drug use	☐ Other

➢ **Allergies**: ☐No ☐Yes (please specify)	➢ **Exercise Tolerance:**
	I get short of breath when I walk around the block ☐ No ☐ Yes

➢ **Medications:** ☐ Not taking medication

☐ Yes: *Please complete list of all medications prescribed include over the counter or when needed*

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			5.		
2.			6.		
3.			7.		
4.			8.		

SURGEON'S OFFICE TO COMPLETE:

Surgeon's Plan of Care (Procedure):____________________

Expected Date of Surgery: ____________________

Name of Surgeon:____________________

Patients BMI	B/P	Pulse	RR	Temp ☐ No ☐ Yes _____

Problem List

1	2	3	4

Surgeon Request: ☐ Patient to be contacted by Anesthesiologist Requires reason: ____________

Screening tool completed by Surgeon/Designee: ____________________ Date: ____________

Please Print Clearly