PRE-OP QUESTIONNAIRE

DOUGLAS ICHIKAWA, D.P.M.

Patient Name: ______________________________________ Today's Date: ________________

Regarding the foot problem that your foot/ ankle surgery is addressing

Describe the surgery you are having:

____

____

____ ▢ LEFT ▢ RIGHT

How long have you had the problem the surgery is addressing? _______ MONTHS / YEARS

What other treatments have you tried? ____

▢Changing activities/ resting ▢Changing shoes ▢Orthotics ▢Physical Therapy ▢Injections ▢Padding

Your pharmacy for postoperative medications: ____________________________________

Regarding your postoperative rehabilitation

How long are you expecting to be on your back with your foot up? ___________ DAYS

How long are you expecting to be on crutches? ______________ WEEKS

How long are you taking leave from work? ______________ DAYS / WEEKS

How long until you expect to drive? _______________ DAY / WEEKS

Who will help you the first few days? Name: _________________________________

What is the number I can call **you** at night before surgery? (____) ______ - ______

Are you familiar with the use of crutches? ▢ YES ▢ NO

Do you have proper fitting crutches at home? ▢ YES ▢ NO

Do you have any fears or reservations regarding the upcoming surgery? ▢ YES ▢ NO

OFFICE USE ONLY:

*Anesthesia and post-op pain control *Recovery guidelines *Post-Op visits

▢Pre-Op clearance needed ▢EKG ▢Scooter / crutches RX ▢Insulin plan ▢Metformin plan ▢FMLA

- Heart:
- Lungs:
- Pedal pulses:
- HAV:
- ROM 1st MTPJ:
- 1st ray ROM:
- X-ray: IM ___________
- Hav:

▢ Vicodin ▢ Vistaril ▢ Ibuprofen ▢ Kefzol ▢ Lovenox 40 mg SQ ▢ ASA 325 BID

PATIENT HEALTH ASSESSMENT – PRE-ANESTHESIA CLINIC

Name:____	**Height:** _________	**Weight:**________
In the past year, how many times have you been admitted to a hospital? ____________________________		
Primary Care Provider Name and Number:____		

Check ANY that applies: ☐ Short of breath at rest ☐ Unable to exercise due to physical limitation
☐ Able to walk 1 city block (200 yards) ☐ Able to climb 1 flight of stairs without stopping ☐ 2 flights or more?
☐ Exercise regularly, if yes, How many times per week?______what type of exercise?______________________
☐ Able to lay flat and still for 30 minutes (without shortness of breath, coughing or moving)?

Have you ever had any of the items below?	**NO**	**YES**	**If YES, please give details and dates**
Any surgery	☐	☐	Please list ALL surgeries in the comment section of page 3
Any anesthesia problems	☐	☐	
Family history of anesthesia problems	☐	☐	
Currently pregnant	☐	☐	
Do you have an advanced directive	☐	☐	
☐ Heart attack ☐Heart stents ☐Heart surgery	☐	☐	When?
Chest / Heart pain / tightness: ☐ When walking ☐ At rest	☐	☐	☐ In last 3 months?
Heart failure history	☐	☐	Current symptoms:
Heart valves problems or surgery	☐	☐	Which valve?
Atrial fibrillation/ Irregular heartbeat Heartbeat too fast or too slow	☐	☐	Current symptoms:
Pacemaker or defibrillator	☐	☐	
Fainting / near fainting in the last year	☐	☐	
Other heart conditions	☐	☐	
High blood pressure	☐	☐	
Leg pain when walking due to blocked arteries	☐	☐	☐ stent placed in leg artery
Pulmonary hypertension	☐	☐	
Recent trouble breathing	☐	☐	☐with activity ☐At rest
Sleep Apnea ☐Using CPAP/BiPAP	☐	☐	
Pneumonia/ Bronchitis with fever or antibiotics use	☐	☐	☐ In last month?
Asthma ☐ history of ER visits or hospitalization	☐	☐	
COPD/Emphysema	☐	☐	
Wheezing	☐	☐	☐ If yes, in last month?
Daily cough ☐ Bring up phlegm daily	☐	☐	
Home oxygen	☐	☐	How much?
Current Tuberculosis	☐	☐	
Current fever, shaking chills, soaking night sweats	☐	☐	
TMJ/ Mouth/ jaw trouble?	☐	☐	
Difficulty with speech or swallowing	☐	☐	

Have you ever had any of the items below?	NO	YES	If YES, please give details and dates
Acid reflux/Heart burn or Ulcer	☐	☐	
Liver disease or current yellow skin or eyes	☐	☐	
Cirrhosis or ascites	☐	☐	
Diabetes ☐Type I ☐Type II ☐ on insulin	☐	☐	Last A1C:
Thyroid Issues☐Goiter ☐Hypo (low) ☐Hyper (high)	☐	☐	
Low kidney function/disease (other than stones)	☐	☐	If on dialysis, which days?
Blood count too high / too low(Anemia) (circle which)	☐	☐	
Excessive bleeding (please elaborate)	☐	☐	
Blood clots in legs / DVT or lungs / PE	☐	☐	
Blindness / Glaucoma (circle which)	☐	☐	
Cancer Type? Treatment?	☐	☐	When?
Organ Transplant which organ?	☐	☐	When?
Current skin infection or open wounds	☐	☐	
Ever told you have MRSA ☐treated	☐	☐	When?
Arthritis ☐with neck involvement	☐	☐	
Steroids, prednisone or immunotherapy (including IV)	☐	☐	In the last year?
HIV	☐	☐	
Autoimmune disease	☐	☐	
Stroke or TIA ☐remaining symptoms	☐	☐	When?
Neurologic disease, causing weakness	☐	☐	
Seizures	☐	☐	When was last one?
Current psychiatric care	☐	☐	
Significant memory loss / dementia	☐	☐	
Need help with your self-care at home (e.g. bathing)	☐	☐	
Need help with daily activities (e.g. running errands)	☐	☐	
Physical disability	☐	☐	
Prescription pain medications more than 2 months?	☐	☐	
Use a pain pump or stimulator? What type?	☐	☐	
Methadone / suboxone / buprenorphine / naltrexone	☐	☐	
Any street drug use in last 6 months? (not including marijuana) If yes: any IV use? ☐No ☐Yes	☐	☐	
Cigarette use: ☐Never ☐Current ☐Quit Other tobacco ☐Cigars ☐E-cigs ☐ pipe	☐	☐	If smoked cigarettes, how many years________ Packs per day_______ If quit, when? _______
Number of alcoholic drinks in a typical week_______ ☐ some days have more than 3 drinks in a day	☐	☐	
Are you experiencing homelessness?	☐	☐	

Current Medications (Including over the counter, dietary supplements, herbal medications), (OK to attach list):
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
Allergies (please describe reactions), (OK to attach list):
1
2
3
4
5

Comments (If need more space please attach more pages):

PATIENT SIGNATURE	PRINT NAME	DATE	TIME