

Modern anesthesia is very safe, but like any medical procedure, there are risks. Major problems, even death or major disability can occur even in the best situation; however, these are very rare. Before surgery, you will be interviewed by an Anesthesia Provider and at the time, the risks and benefits of the types of anesthesia will be fully discussed with you and a final choice of anesthetic will be made. Please feel free to ask questions about your anesthesia care. Please complete and sign the following questionnaire. This will be reviewed by the Anesthesia staff and will be very helpful in determining the most appropriate anesthetic for you.

<b>NAME OF PATIENT:</b>		<b>PHONE NUMBER:</b>	
<b>AGE</b>	<b>GENDER</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>HEIGHT</b> inches	<b>WEIGHT</b> lbs

Allergies?  Yes  No If yes, please list what you are allergic to and the reaction.

Latex Allergy?  Yes  No

<b>PLANNED SURGICAL PROCEDURE:</b>	<b>Planned Date of Procedure:</b>
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**PAST SURGERIES & ANESTHESIA**

Date	Procedure	Anesthesia (General, Spinal, Epidural, Sedation, etc.)	Problems, if any

**CURRENT MEDICATIONS:** List all medications you are taking, including over-the-counter (e.g., aspirin, antacids, vitamins and herbals). The records in the computer-generated list are not always up-to-date. It is very important to have a complete list of the current medications you are taking in order to provide the safest care possible. If you do not know all of the medications you are on please bring a list with you on the day of your procedure.

Medication	Dosage	# of times you take per day, or state "as needed"

**PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has anyone in your family had significant <b>problems with anesthesia</b> (death, high fever/malignant hyperthermia, delayed awakening)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a <b>breathing tube placed</b> ? If yes, were you told it was <b>difficult</b> ?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there any possibility that you are or might become <b>pregnant</b> before the procedure?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had <b>cold symptoms</b> (cough, runny nose, fever, difficulty breathing) in the past 4 weeks?

**HAVE YOU EVER HAD THE FOLLOWING? If yes, please explain in the space provided.**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Lung or breathing problems?</b> (COPD/emphysema/asthma/pneumonia/severe or recurrent bronchitis)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Tobacco use?</b> Average packs per day _____ X _____ years Quit? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Obstructive Sleep Apnea (OSA)?</b> CPAP/BiPAP machine? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Heart problems</b> (heart attack/chest pain/irregular heartbeat/murmur/heart failure/loss of consciousness/defibrillator/pacemaker)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Vascular problems</b> (peripheral arterial disease, stent/graft surgery)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Kidney problems</b> (renal failure/dialysis/stones)? <input type="checkbox"/> Peritoneal Dialysis
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Gastrointestinal problems</b> (heartburn/reflux/ulcer/diarrhea)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Liver problems</b> (hepatitis/cirrhosis/jaundice)?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Diabetes?</b> Insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Thyroid problems</b> (hypothyroid/hyperthyroid/Graves)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Steroid use</b> in past 6 months?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Blood disorder</b> (sickle cell/bleeding disorder/prior transfusion)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Cancer?</b> Type: <b>Chemotherapy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type of medication: Radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Neurologic problems</b> (weakness/nerve injury/seizure/stroke/recurrent severe headaches)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Mental health issues</b> (depression, anxiety, PTSD, bipolar, etc.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Muscle/bone/joint problems</b> (arthritis/weakness/muscular dystrophy)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Skin problem</b> (current infection/MRSA)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Eye problem</b> (glaucoma)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Other medical problems?</b>

**MISCELLANEOUS QUESTIONS**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had surgery at Naval Medical Center San Diego in the past year?
Females only:	All females receive a pregnancy test on the day of surgery unless they are post-menopausal or have had a hysterectomy. Please check if this applies to you. Post-menopausal <input type="checkbox"/> Hysterectomy <input type="checkbox"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No	On the day you are coming in for your procedure are you scheduled to have any other procedures, labs drawn or other tests? If yes please explain
<input type="checkbox"/> Yes <input type="checkbox"/> No	On your day of surgery, is there any reason that you would not be able to come in at 0500-0630? If yes, please explain:

**POST-OPERATIVE NAUSEA AND VOMITING (PONV) SCREENING      # OF POINTS:    + 1 =    (all start with one point)**

<input type="checkbox"/> Yes (1) <input type="checkbox"/> No	Female Gender?
<input type="checkbox"/> Yes <input type="checkbox"/> No (1)	Do you smoke?
<input type="checkbox"/> Yes (1) <input type="checkbox"/> No	History of post-operative nausea or motion sickness?

**OBSTRUCTIVE SLEEP APNEA (OSA) SCREENING      # OF YES ANSWERS:**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you SNORE loudly or have you been diagnosed with SLEEP APNEA? (Louder than talking or loud enough to be heard through closed doors)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you often feel Tired, fatigued, or sleepy during daytime?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has anyone OBSERVED you stop breathing during your sleep?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have or are you being treated for high blood PRESSURE?
<input type="checkbox"/> Yes <input type="checkbox"/> No	AGE over 50 years old?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Male GENDER?

Next two Questions below completed by PAC Staff

<input type="checkbox"/> Yes <input type="checkbox"/> No	NECK circumference > 15.75 inches? (Neck Circumference: _____ inches)
<input type="checkbox"/> Yes <input type="checkbox"/> No	BMI more than 35? BMI _____ (Height: _____ inches / Weight: _____ lbs.)

**MULTI-DRUG RESISTANCE ORGANISM (MDRO) SCREENING      # OF YES ANSWERS:**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been told by a physician that you have had any Multi Drug resistant organism infection or colonization?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you recently been a patient in a trauma unit, Skilled nursing facility or been in combat theater of operations and have an open wound?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a skin or soft tissue infection?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a dialysis patient or have you been hospitalized within the last 30 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	The previous statements are true to the best of my knowledge.

Patient Signature (or Parent/Legal Guardian)

## **ADULT SURGERY PREADMISSION INSTRUCTIONS**

1. I am scheduled for surgery on \_\_\_\_\_. My surgeon is \_\_\_\_\_.
2. I **will** complete all ordered labs, x-rays, and diagnostic tests today unless otherwise instructed.
3. I **will not** eat, drink alcohol, smoke, or chew tobacco, gum or candy after midnight the night before my surgery. I may drink clear liquids up to 2 hours prior to my scheduled surgery arrival time. The following are acceptable clear liquids: Water, clear apple juice, 7-up/Sprite, Pedialyte, Gatorade or other sports drink, black coffee (No creamer). **NO OTHER CLEAR LIQUIDS ARE AUTHORIZED AT NMCS D.**
4. I will take a shower and wash the area of surgery twice the night before and once the morning of surgery as instructed with:  
 Antibacterial soap    2% HCG Cloth    N/A    hibiclens®    betadine    Other
5. I will not wear makeup or nail polish. (DO NOT APPLY LOTION, PERFUME, COLOGNE, SCENTED DEODORANT, OR POWDER AFTER SHOWERING. DO NOT SHAVE AREA OF SURGERY).
6. I will **not** take aspirin, aspirin containing products or anti-inflammatory medication (Motrin®, Advil®, Naprosyn®, Ibuprofen, Celebrex®) for 2 weeks prior and during post-operative care **unless otherwise directed by my surgeon** (excluding Ophthalmology patients). Patients, who have had heart stents, please consult your cardiologist before stopping any medication.
7. I will complete all pre-op preparations as instructed by my surgical clinic:    Colyte®    Enema    Fleets Phosphosoda ®    Magnesium Citrate®    Other \_\_\_\_\_
8. I **will** take regularly scheduled medications with a sip of water the morning of surgery unless otherwise instructed by anesthesia and/or my surgeon.
9. I will bring my Military ID Card for identification purposes or any other necessary paperwork. If you have an advanced directive, please bring it on the day of surgery. If you would like information about advanced directives, you may obtain this information at the front desk or at the NMCS D legal department.
10. I will bring crutches, braces, or support garments as directed by my surgeon. I will bring containers and solutions for contact lenses, glasses, dentures, hearing aids, and a small bag with toiletries if staying overnight.
12. I will not bring jewelry (including wedding bands and body jewelry/piercings), money, credit cards or other valuables. If I choose to keep valuables or prosthetics such as glasses, dentures, or hearing aids, I understand that I assume liability and agree to hold harmless the U.S., the Dept. of the Navy, NMCS D, and/or any employee or agents of the foregoing for any claim that might arise as the result of loss of such valuables or personal effects.
13. I will call my surgeon if I develop a fever, rash, cold, or other illness between now and my scheduled date of surgery.
14. Only ONE person is allowed to accompany you into the pre-operative area. Children under 12 years old are not permitted.
15. I **will** have a responsible adult to take me home and stay the night after being discharged. **Active duty members CANNOT spend the night in the barracks or on the ship.**
16. Active Duty: A signed **AND** approved copy of your Command Authorization for Surgery form is required to be faxed no **later than noon the day before surgery** to 619-532-8363. (Bring a copy on your surgery day.)   Confirm receipt by calling 619-532-6530.
17. If I do not receive an automated message by 4 PM one business day prior to surgery I will call (619) 532-6844 (option 1) or (619) 532-6335 for my arrival time. The unit is closed on weekends and holidays and you should call (619)532-9000 for your time.
18. I will check-in day of surgery at the Main Operating Room surgery check-in window located on the 4<sup>th</sup> floor of building 1.
19. If you have any other questions, please contact your surgical clinic.

**I acknowledge I have read and understand the preoperative instructions as stated above. Not following these instructions may result in case delay or cancellation!**

\_\_\_\_\_  
Patient / Legal Guardian Signature / Date

\_\_\_\_\_  
Nurse/Corpsman Signature / Date

NMCS D 6000/31(5/14)

**Patient Label**