NYU Hospitals Center

Pre-Admission Testing Patient Screening Questionnaire

Patient Name:	**Date of Birth:** **MRN:**

Surgery requiring S. Aureus Screening or Skin Antisepsis wipes require PAT visit* **Surg** John Kennedy

Surgical Coordinator Contact Information (Phone and Email):	**Date of Surgery:**
Primary Care Provider **Phone:**	**Cardiologist/Specialist Dr.:** **Phone:**
BP: **HR:** Wheelchair bound? Bedridden?	Height: Weight:

YES	NO		YES	NO	
☐		Do you have or are you being treated for high blood pressure? *If yes, how many years?*	☐		Have you ever had a heart valve replacement or repair?
☐		Do you have chest pain with walking/normal activity? With exercise?	☐		Do you have a pacemaker or defibrillator?
☐		Have you ever had a coronary bypass or angioplasty?	☐		Have you ever been told that you have a widening of your aorta or that you have an aortic aneurysm?
☐		Have you ever had a heart attack? *If yes, how many?: When?:*	☐		Have you ever been told you have peripheral vascular disease?
☐		Do you have a heart stent? *If yes, how many?: When?:*	☐		Have you ever had a stress test? *If yes, where?: When?: Why?:*
☐		Do you have a weak or failing heart (congestive heart failure, CHF)?	☐		Have you ever had a cardiac echo test? *If yes, where?: When?: Why?:*
☐		Do you have an irregular heartbeat or heart rhythm?	☐		Have you ever had a heart catheterization? *If yes, where?: When?: Why?*
☐		Do you have a heart murmur or mitral valve prolapse?			
☐		Do you take daily medication for asthma?	☐		Do you have difficulty breathing (do you wheeze)?
☐		Do you have a history of chronic bronchitis or emphysema (COPD- Chronic Obstructive Pulmonary Disease)?	☐		Do you use supplemental oxygen?
☐		Do you smoke? *If yes, how many packs / day?: How may years have you been a smoker?:*	☐		Do you have a history of sleep apnea? CPAP-Continuous Positive Airway Pressure?
☐		Have you had any recent colds, fever or flu symptoms?	☐		Have you ever been witnessed to stop breathing while asleep?
☐		Do you have diabetes? *If yes, for how many years?: Complications?:*	☐		Do you take insulin?
☐		Do you have kidney problems (other than kidney stones)?	☐		Have you ever had Hepatitis A / B / C / D? (circle)
☐		Do you have liver problems?			
☐		Do you drink alcohol every day? *If yes, how many drinks/day?:*	☐		Do you use recreational drugs? *If yes, specify:*

Please Turn Over To Continue

NYU Langone MEDICAL CENTER

Patient Nar

Medical Record Number:_____

NYU Hospitals Center

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YES	NO		YES	NO	
☐		Do you have a history of anemia?	☐		Do you have a history of sickle cell disease or trait?
☐		Do you take any blood thinners (e.g. Coumadin)?	☐		Do you have a history of cancer?
☐		Do you take Aspirin or Ibuprofen regularly?	☐		Are you on Chemo Therapy?
☐		Do you have seizures or take anti-seizure medications?	☐		Do you have neuromuscular disease (including Parkinson's, ALS etc)?
☐		Have you ever had a stroke(CVA), mini stroke(TIA) or brain attack? *If yes, when?:*	☐		Do you have a brain tumor, brain aneurysm or other vascular lesion of the brain?
☐		Have you been told that it is difficult to place a breathing tube in your airway (intubate)?	☐		Do you have a history of severe reaction to anesthesia?
☐		Do you or a family member have a history of high fever after anesthesia (malignant hyperthermia)?	☐		Do you suffer from chronic pain?
☐		Do you have a history of severe nausea and vomiting after anesthesia?	☐		Is there a possibility you could be pregnant? *LMP:*
☐		Do you have an autoimmune disease (e.g. Rheumatoid Arthritis, Sarcoidosis or Lupus)?	☐		Do you have any other medical problems that we have not asked you about? *If yes, specify:*

OFFICE USE: EKG results good for 6 months. Chemistry lab results good for 3 months

Please list the medications you currently take and the dose.

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____