Texas Orthopedic Hospital
Pre-Operative Health Assessment

We welcome the opportunity to participate in your medical care. To ensure maximum safety and efficiency, we ask that you provide accurate answers to these questions regarding your health. Thank you for your help and we look forward to caring for you.

Patient Name: _____ Date: _____

Age: _____ ☐ Male ☐ Female Height: _____ Weight: _____

Immunizations Current: (if patient less than 19 yrs.) ☐ Yes ☐ No

List all Allergies (Food, Drug, Metal, Tape)	**Reactions**	**List all Medications you currently use (Including diet pills)**

List all previous Surgeries:

List over the counter drugs you currently use (include herbals and vitamins):

Name	**Dose**	**Frequency**

Anesthesia	**Yes**	**No**	**Comments**
1. Have you ever had an anesthesia?	☐	☐	What type? ☐ ? Local ☐ ? Regional ☐ ? General
2. Have you ever had a problem with anesthesia?	☐	☐	
3. Any family history of malignant hyperthermia or unexpected death under anesthesia?	☐	☐	
Respiratory			
4. Do you Smoke? How many packs per day and for how many years?	☐	☐	
5. Do you currently have a cough?	☐	☐	
6. Have you ever had asthma? When was your last attack?	☐	☐	
7. Do you currently or chronically have bronchitis, sinusitis, or emphysema?	☐	☐	
8. Have you ever had tuberculosis? If yes, how was it treated?	☐	☐	
9. Have you ever had an abnormal chest x-ray?	☐	☐	
10. Have you ever been diagnosed with sleep apnea? Do you ever stop breathing at night? Do you snore loudly?	☐	☐	
Cardiovascular			
11. Do you become short of breath when walking up two flights of stairs?	☐	☐	
12. Do you exercise regularly? What type?	☐	☐	
13. Are you short of breath at night?	☐	☐	
14. Do you have a heart murmur? Mitral valve prolapse?	☐	☐	
15. Have you ever had a heart attack?	☐	☐	
16. Have you ever had angina and/or pain in the chest related to your heart?	☐	☐	
17. Have you ever had hypertension or high blood pressure?	☐	☐	
18. Have you ever had an abnormal EKG?	☐	☐	

Renal			
19. Have you ever had kidney disease?	☐	☐	
20. Have you ever had problems urinating?	☐	☐	
Neurological	**Yes**	**No**	**Comments**
21. Have you ever had a stroke or meningitis?	☐	☐	
22. Do you have an arm or leg that becomes numb, weak, or swells?	☐	☐	
23. Have you ever had seizures, episodes of unconsciousness, or fainting?	☐	☐	
24. Have you ever had an eye problem, problem with your vision or glaucoma?	☐	☐	
Gastrointestinal			
25. Have you ever had hepatitis, liver disease or been jaundiced?	☐	☐	
26. Do you have frequent heartburn, indigestion or gastric reflux?	☐	☐	
27. Do you drink alcohol? If so, how much and how often?	☐	☐	
28. Do you have problems with bowel movements?	☐	☐	
Endocrine			
29. Have you been on steroids anytime in the past six months?	☐	☐	
30. Do you have diabetes?	☐	☐	
31. Have you ever had a thyroid problem?	☐	☐	
Musculoskeletal			
32. Do you have a back or neck problem?	☐	☐	
33. Do you have arthritis?	☐	☐	
34. Do you have any physical disabilities?	☐	☐	
General			
35. Any skin problems?	☐	☐	
36. Any history of sexually transmitted diseases?	☐	☐	
37. Do you have any bleeding tendencies?	☐	☐	
38. Have you ever been anemic?	☐	☐	
39. Have you had aspirin in the past two weeks? Or any products containing aspirin? If so, how much?	☐	☐	
40. Do you have chipped or loose teeth? Dentures, caps, bridgework, braces?	☐	☐	
41. Have you ever been under the care of a psychiatrist?	☐	☐	
42. Have you given blood for this hospitalization?	☐	☐	
43. Has someone else given blood for you?	☐	☐	
44. Do you wear glasses or contacts?	☐	☐	
45. Have you ever had cancer? Specify type.	☐	☐	
46. Is there anything else you feel we should know?	☐	☐	
Females			
47. Are you pregnant?	☐	☐	
48. Date of last menstruation (period). / / Month Day Year			

Any other comments? _____

Name of your family or medical physician: _____

Patient's Signature: _____ Date:

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