Charles A. Dean Memorial Hospital
EMHS MEMBER

Pre Operative Visit Screen

Please fill out this form and bring with you, the day of surgery.

	Yes	***No***
Do you have blood pressure problems?	_____	_____
Do you have any blood vessel problems?	_____	_____
Have you ever had a stroke/mini stroke	_____	_____
Do you have any chest pain? Have you ever had a "heart attack"? When_____	_____	_____
Do you have a pacemaker or implantable cardiac device?	_____	_____

If yes, you must provide a copy of the device card.

When you come in for your Lab/EKG work, give a copy of the device card to Hospital Registration. The device card copy will be provided to the Anesthesia Department.

- Where was the device implanted? _____

Do you have asthma?	_____	_____
Have you recently had bronchitis/pneumonia?	_____	_____
Do you have difficulty breathing?	_____	_____
Do you smoke? _____ How frequently? _____	_____	_____
Do you have dentures?	_____	_____
Do you have any loose or capped teeth?	_____	_____
Have you ever had hepatitis or other liver problems?	_____	_____
Do you have diabetes?	_____	_____
Do you have thyroid problems?	_____	_____
Do you have kidney problems?	_____	_____
Do you have hiatal hernia?	_____	_____
Do you have a seizure disorder?	_____	_____
Do you have glaucoma?	_____	_____
Do you have bleeding problems?	_____	_____
Do you have back problems?	_____	_____
Do you have any nerve or muscle disorder?	_____	_____
Do you have arthritis?	_____	_____
Have you taken steroids?	_____	_____
Have you ever had an anesthetic?	_____	_____
Have you ever had a problem with anesthesia?	_____	_____
Have any relatives had problems with anesthesia?	_____	_____
Do you have known obstructive sleep apnea ?	_____	_____
If yes do you use Bipap or Cpap	_____	_____

List types of surgeries you have had:

_____

_____

Are there any other health issues that we need to be aware of?_____

List allergies:_____

Signature: _____ Date: _____Time_____

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