Pre-Operative Health Assessment
(PLEASE FILL OUT CURRENT MEDICATION SHEET)

Our goal at Texas Orthopedic Hospital is to help you reach a pain rating-comfort/function goal that will enable you to eat, sleep, or perform other physical activities. The pain rating-comfort/function goal can be thought of as one in the same for you to perform activities related to your recovery and improved quality of life. We will ask you regularly about your pain rating-comfort/function goal, but if at anytime you have pain that is interfering with your comfort/function goal you must let us know. Please rate a realistic pain comfort goal that will enable you to perform the activities necessary to aid in your recovery (Circle number)

0☐ **1**☐ **2**☐ **3**☐ **4**☐ **5**☐ **6**☐ **7**☐ **8**☐ **9**☐ **10**☐

NO PAIN — WORST POSSIBLE PAIN

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Pneumonia vaccine / date: _____

Immunizations current (if patient less than 19 yrs.)?: ☐ Yes ☐ No Flu shot / date: _____

List all Allergies (Food, Drug, Metal, Tape)	**Reactions (What happens when you take it?)**

List ALL Previous Surgeries/Procedures/Were any at TOH?	**Month/Year of Surgeries/Procedures**

Anesthesia	**Yes**	**No**	**Comments?**
1. Have you ever had 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	**Yes**	**No**	
4. Do you smoke? How many packs per day and for how many years? Have you ever smoked?			
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 or a positive PPD skin test? If yes, how was it treated?			
9. Have you ever had a chest x-ray that was not normal?			
10. Have you ever been diagnosed with sleep apnea? CPAP? Do you ever stop breathing at night or snore loudly?			
Cardiovascular (circle one)	**Yes**	**No**	
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 or coronary stent placed?			
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 including AFib/A flutter?			
19. Do you have a pacemaker and/or defibrillator?			
20. Do you have congestive heart failure (CHF)?			
Renal	**Yes**	**No**	
21. Have you ever had kidney disease?			
22. Have you ever had problems urinating?			

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

Any other comments/medical conditions?

Environment

☐ ☐ ☐ ☐
Do you live in a: HOUSE (1 STORY) / HOUSE (2 STORY) / APARTMENT / TRAILER (CIRCLE ONE)

Who do you live with? _____

☐ ☐ ☐ ☐
How do you learn best? VISUAL / WRITTEN MATERIAL / VERBAL / AUDITORY (CIRCLE ALL APPLICABLE)

☐ ☐ ☐ ☐
What equipment do you currently own? WALKER / CRUTCHES / BEDSIDE COMMODE / WHEELCHAIR (CIRCLE ALL APPLICABLE)

Name of your family or medical physician:

Patient's Signature:_____ **Date:**_____

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