Date: PREADMISSION TESTING SCREENING FORM		
Please answer the following questions:		
 Do you have sleep apnea; use a CPAP or BiPAP; or have you been told you need a "sleep study? 	YES 🗆	NO 🗆
 Do you have difficulty climbing stairs or walking 4 blocks? IF YES, WHAT STOPS YOU: 	YES 🗆	NO 🗆
CHEST PAIN Shortness of Breath PAIN (Body, other than chest) OTHER:		
3. DO YOU (or have you had) HAVE HIGH BLOOD PRESSURE? HOW MANY MEDICATIONS DO YOU TAKE FOR IT? (Circle One) 1 2 3+	YES 🗆	NO 🗆
4. Have you ever had a blood clot, stroke, blocked arteries or a mini stroke?	YES 🗆	NO 🗆
Are you currently taking blood thinners, such as, Aspirin, Coumadin, Plavix, ect?	YES 🗆	NO 🗆
6. Do you have problems with bleeding after a surgical or dental procedure?	YES 🗆	NO 🗆
7. Do you have a history of Liver Disease or Cirrhosis?	YES 🗆	NO 🗆
8. Have you ever had a heart attack, or problems with your heart? (Such as Heart Failure, "enlarged" heart, Heart Surgery, ect,,,)	YES 🗆	NO 🗆
Do you currently have chest pain episodes?	YES 🗆	NO 🗆
9. Do you have Diabetes?Do you have to take insulin for it?	YES YES	NO 🗆
 Have you ever had problems with Anesthesia (OTHER THAN NAUSEA OR VOMITTING)? (Ex: Difficult airway?) 	YES 🗆	NO 🗆
11. Do you have kidney problems (other than stones or UTI's), such that you must see a kidney specialist or on Dialysis? (CKD, Creatinine >2)	YES 🗆	NO 🗆
12. Are you pregnant or is there a chance you could be pregnant?	YES 🗆	NO 🗆
13. Do you have any implanted devices? CIRCLE ONE: Pacemaker/ Defibrillator? CARDIAC Stent (What year)? Insulin pump? OTHER?	YES 🗆	NO 🗆
14. Are you currently a daily smoker?	YES 🗆	NO 🗆
15. Do you drink at least 2 alcoholic beverages daily?	YES 🗆	NO 🗆
16. Current recreational or illicit drug use?	YES 🗆	NO 🗆
17. Do you have Asthma, COPD or any other lung disease?	YES 🗆	NO 🗆
18. How much do you weigh?	BMI >30?	BMI >40?
19. How tall are you?		

Patient Name: _____ DOB: _____ Surgeon: _____

If there any YES answers, patient must be scheduled for a PAT appt at ECMC.