Patient Name: _____ DOB: _____ Surgeon:_____

Date: _____ **PREADMISSION TESTING SCREENING FORM**

| **Please answer the following questions:** | | |
|---|---|---|
| 1. Do you have sleep apnea; use a CPAP or BiPAP; or have you been told you need a "sleep study? | YES ☐ | NO ☐ |
| 2. Do you have difficulty climbing stairs or walking 4 blocks?<br>➢ IF YES, WHAT STOPS YOU:<br>CHEST PAIN ☐ Shortness of Breath ☐ PAIN (Body, other than chest) ☐<br>OTHER:_____ | YES ☐ | NO ☐ |
| 3. DO YOU (or have you had) HAVE HIGH BLOOD PRESSURE?<br>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 ☐ |
| 5. 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?<br>(Such as Heart Failure, "enlarged" heart, Heart Surgery, ect,,,)<br>➢ Do you currently have chest pain episodes? | YES ☐<br>YES ☐ | NO ☐<br>NO ☐ |
| 9. Do you have Diabetes?<br>➢ Do you have to take insulin for it? | YES ☐<br>YES ☐ | NO ☐<br>NO ☐ |
| 10. 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?<br>CIRCLE ONE: Pacemaker/ Defibrillator? CARDIAC Stent (What year)?<br>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?<br>19. How tall are you?<br>➢ CALCULATE BMI: _____ | BMI >30? | BMI >40? |

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