Methodist Hospital of Sacramento
A Dignity Health Member

Anesthetic Questionnaire

Patient's Name: _____ Date: _____

Date of Surgery: _____ Surgeon: _____ Family M.D.: _____ Cardiologist: _____

Age: _____ Height: _____ Weight: _____ Sex: ☐ M ☐ F Have you been a patient here before? _____ yr. _____

DRUG ALLERGIES: _____ Latex Allergy? ☐ Yes ☐ No

Please List Any Medication, Injection, or Pills Taken on a Regular Basis:

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

LIST ADDITIONAL MEDICATIONS ON SEPARATE PAPER

Have you had Anesthesia before?
If yes, which: GEN / LOC / SPINAL _____

Have you or any blood relative had a problem with anesthesia? ☐ Yes ☐ No

What? _____

Have you had post-op nausea? ☐ Yes ☐ No

☐ Mild ☐ Moderate ☐ Severe

List Previous Operations:

1 _____ (_____ yr.) 2 _____ (_____ yr.) 3 _____ (_____ yr.) 4 _____ (_____ yr.) 5 _____ (_____ yr.)

DO YOU HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?
PLEASE CHECK APPROPRIATE COLUMN AND CIRCLE CHOICE.

YES	NO	
		HEART PROBLEMS - IF YES, WHAT? _____
		HIGH OR LOW BLOOD PRESSURE, IF YES CIRCLE ONE.
		STROKE? WHEN? _____
		LUNG PROBLEMS OR PNEUMONIA OR TUBERCULOSIS?
		ASTHMA OR SLEEP APNEA?
		EPILEPSY, SEIZURES OR MULTIPLE SCLEROSIS?
		BLEEDING PROBLEMS?
		BLOOD TRANSFUSIONS?
		KIDNEY OR URINARY PROBLEMS?
		NERVOUS OR EMOTIONAL PROBLEMS?
		ARTHRITIS?
		LIVER PROBLEMS - IF YES, WHAT IS PROBLEM? _____
		HAVE YOU EVER HAD HEPATITIS OR HIV? IF YES, WHAT TYPE? _____
		CANCER - IF YES, WHAT TYPE? _____
		INDIGESTION, HIATAL HERNIA OR GASTRIC REFLUX?
		DIABETES, RAYNAUD'S OR BERGER'S DISEASE?
		MYASTHENIA GRAVIS OR GUILLAIN-BARRÉ DISEASE
		HAVE YOU USED ANY RECREATIONAL DRUGS IN THE PAST MONTH?
		IS THERE ANY POSSIBILITY YOU COULD BE PREGNANT?
		HAVE YOU TAKEN ANY STEROID PREPARATIONS IN THE PAST YEAR? (PRED. CORTISONE, ETC.)
		HAVE YOU TAKEN ASPIRIN, PLAVIX OR COUMADIN IN THE LAST 5 DAYS?
		WERE YOU SEEN PREOPERATIVELY BY A MEDICAL DOCTOR FOR CLEARANCE? IF YES, DR. _____

YES	NO	SICKLE CELL
		HAVE YOU BEEN TESTED FOR SICKLE CELL TRAIT?
		DOES ANYONE IN YOUR FAMILY HAVE THE SICKLE CELL TRAIT?
		DO YOU HAVE ANEMIA DUE TO SICKLE CELL DISEASE?

Do You Smoke Now? ☐ Yes ☐ No How Much Each Day? _____ packs for _____ yrs.

Have You Ever Smoked? ☐ Yes ☐ No How much: _____ packs for _____ yrs. When quit _____

How Much Alcohol Do You Drink? ☐ None ☐ Seldom ☐ Occasionally ☐ Daily

Patient Signature: _____ Date: _____

ANSWER DAY OF SURGERY

When Did You Last Have Something to Eat or Drink? _____

Do You Have Loose Teeth, Bridgework, Dentures or Caps? ☐ Yes ☐ No ☐ U ☐ L ☐ Partial

Do You Have Any Questions? _____

Pre-op Instructions

1. 7 days prior to surgery: Stop taking Anti-inflammatories. (Aspirin, Ibuprofen, Motrin, Naprosyn, Celebrex, Coumadin, Etc.)

2. 3 days prior to surgery: No alcohol

3. 8 hours prior to surgery: No food or drink (including water) unless otherwise instructed by the pre-admit nurse.

4. Our office will be e-faxing your post op medications to Valley pharmacy 2 days prior to your surgery. Please pick meds up from Valley pharmacy prior to your surgery. **We will not be giving any additional prescriptions**, as the quantity given must last your post op period. If at any time you get constipated, we recommend Senokot-S or Colase, which are both available over the counter. ***DO NOT CALL AFTER HOURS OR ON WEEKENDS***

5. Methodist will be contacting you by phone 2-3 days prior to surgery to go over information. They will be contacting you to let you know what time to arrive at the hospital. We recommend you bring reading material as the wait time for surgery can be 1-2 hours.

6. Please bring/wear loose fitting/comfortable clothes that are easy to re-dress after surgery. If you are staying overnight, you may want your own pillow, slippers, toothbrush, etc.

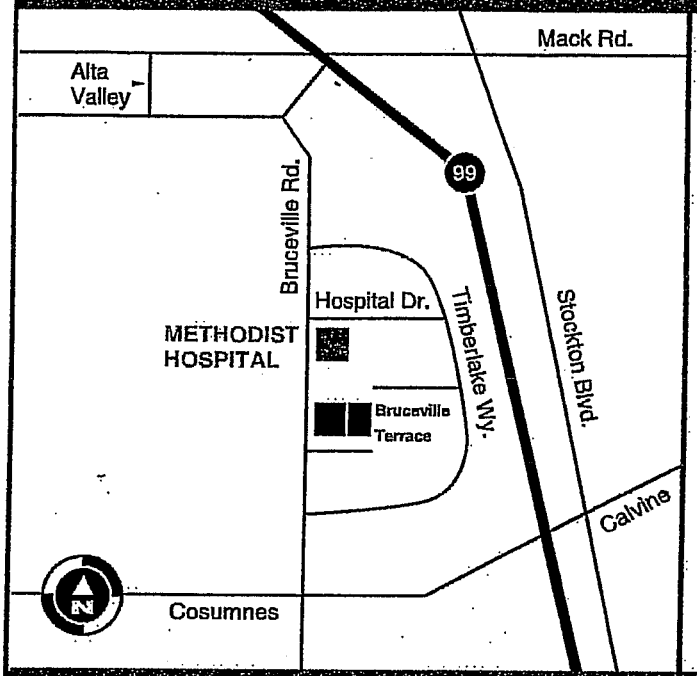
7. If at any time prior to surgery you get a cold, fever, or any illness, please notify our office, as this may cause us to cancel/reschedule surgery.

8. Please do not wear jewelry/piercings to Hospital.

9. Please do not wear any make-up and/or fingernail polish on nails/toes.

10. If you are schedule for a total joint, you will be given a dental card indicating the need for an antibiotic for any dental work. Please obtain medication from your primary physician. Please notify your Dentist and Family MD of total joint replacement.

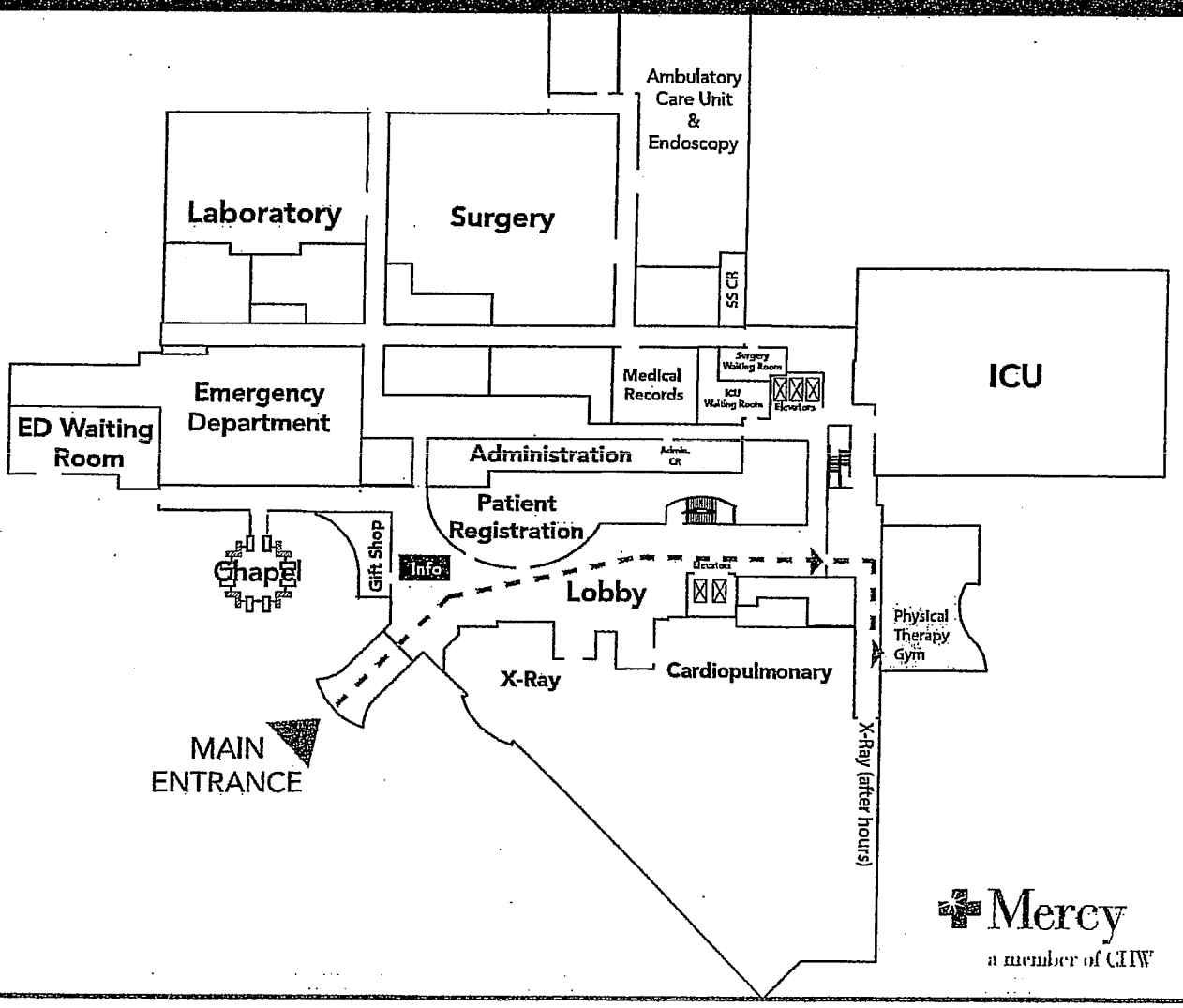
DIRECTIONS TO METHODIST HOSPITAL



METHODIST HOSPITAL
7500 Hospital Drive, Sacramento
Main Phone Number: 916.423.3000

Directions:
From Sacramento, drive south on Highway 99. Take the Calvine/Cosumnes exit. Turn right onto Cosumnes. The first stoplight is Bruceville, turn right onto Bruceville. Turn right onto Hospital Drive. Methodist Hospital will be on your right side.

DIRECTIONS TO REHAB GYM



Mercy
a member of CHW

Harry A. Khasigian, M.D.

Orthopedic Surgery & Sports Medicine
Diplomat, American Board of Orthopedic Surgery
Fellow, American Academy of Orthopedic Surgeons

Physician's Surgery and procedure consent form

Date:_____ Time:_____AM/PM

_____1. I consent to the performance upon (myself/name of patient)_____ the following operation or procedure: (technical name)_____ _____. The purpose of this operation/procedure is (lay language) _____ and will be performed by Harry Khasigian and whomever he may designate as his assistants.

_____2. It has been explained to me that a satisfactory result is expected, but not guaranteed, and the following are some of the complications that could or may occur: pain, bleeding, scarring, suture reaction, delayed healing, infection, damage to adjacent tissues / organs, anesthesia or medication reaction, recurrence, additional operations, and rare instances, paralysis or death.

_____3. The nature and purpose of the operation or procedure, the risks of the operation or procedure, and the possibilities of complications have been explained to me.

_____4. No guarantee or assurance has been given by anyone as to the result that may be obtained.

_____5. I consent to the doctors performing whatever different or additional operations or procedures they deem necessary during the course of the operation.

_____6. I consent to the administration of such anesthetics as may be considered necessary or advisable for this operation or procedure. I understand that the anesthesiologist and I should obtain the necessary information and gain full disclosure from him.

_____7. I am not known to be allergic and do not have tolerance to anything except _____ _____.

_____8. I understand that I am encouraged and invited to ask any questions and all of my questions have been answered to my satisfaction.

CONSENT FOR BLOOD TRANSFUSION

_____9. This is to make you aware that your surgery may necessitate a blood transfusion as a result of the surgical procedure, You have been given information regarding the "positive and negative" aspects of receiving autologous blood and dierected and non-directed homologous blood from volunteers.

The term "autologous" blood indicated, but is not limited to, pre-donation blood, interoperative autologous transfusions (cell saver), or varidyne, plasma plasmapheresis, and hemodilustion.

This consent form indicates that you have been advised of the options and have consented to allow transfusion as necessary during your operation. Your signature also indicates that you have been given opportunity to pre-donate blood.

_____	_____
Patient signature	Date
_____	_____
Printed name	Time
_____	_____
Witness signature	Date
_____	_____
Printed name	Time

MEDICAL CLEARANCE

Your patient _____ is planning surgery, before we can continue scheduling, we are requesting medical clearance.

*** Please include most recent EKG ***

My patient _____ is medically optimized and cleared for surgery.

X _____

Physicians name printed

X _____

Physicians Signature

Date: ___/___/___

~Please fax to Karen at Dr. Khasigian/Dr.D'Amico's Office at (916) 525-0639.

Thank You