

# Critical "Pre-Op" Questions

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Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Nickname: \_\_\_\_\_

Especially Important for Children

Date of Birth (DOB): \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

Medical Number: \_\_\_\_\_

Or Social Security Number

Family Contact, Guardian: \_\_\_\_\_

Significant Other (Especially Important for Children)

Who Is Present? \_\_\_\_\_

Possessions: \_\_\_\_\_

Who Maintains

Possessions? \_\_\_\_\_

Non-Drug Allergies: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

(Shrimp, Peanuts, etc.)

Prep Solution Allergies: \_\_\_\_\_

(Iodine, Betadine, etc.)

Latex Allergies: \_\_\_\_\_

Do You Get Red Marks Around Your Lips When You Blow Up Balloons?

Drug Allergies: \_\_\_\_\_

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# Critical "Pre-Op" Questions Page 2

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Allergies to Dyes: \_\_\_\_\_  
(Especially dyes used in X-raying, MRIs etc.)

Current Medications: \_\_\_\_\_ Dose: \_\_\_\_\_  
\_\_\_\_\_ Dose: \_\_\_\_\_  
\_\_\_\_\_ Dose: \_\_\_\_\_  
\_\_\_\_\_ Dose: \_\_\_\_\_  
\_\_\_\_\_ Dose: \_\_\_\_\_  
\_\_\_\_\_ Dose: \_\_\_\_\_

## Specific Drugs That May Impact your Safety:

Are You Taking Aspirin? \_\_\_\_\_ When? \_\_\_\_\_

What Dose \_\_\_\_\_ Last Dose? \_\_\_\_\_

Are You Taking Coumadin? \_\_\_\_\_ When? \_\_\_\_\_

What Dose \_\_\_\_\_ Last Dose? \_\_\_\_\_

Are You Taking Heparin? \_\_\_\_\_ When? \_\_\_\_\_

What Dose \_\_\_\_\_ Last Dose? \_\_\_\_\_

Are You Taking Steroids? \_\_\_\_\_ When? \_\_\_\_\_

What Dose \_\_\_\_\_ Last Dose? \_\_\_\_\_

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# Critical "Pre-Op" Questions Page 3

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Are You Taking Diuretics? \_\_\_\_\_ When? \_\_\_\_\_

What Dose \_\_\_\_\_ Last Dose? \_\_\_\_\_

Are You Taking Any Other Over The Counter Drugs?

Drug: \_\_\_\_\_ Dose: \_\_\_\_\_

Drug: \_\_\_\_\_ Dose: \_\_\_\_\_

Drug: \_\_\_\_\_ Dose: \_\_\_\_\_

Drug: \_\_\_\_\_ Dose: \_\_\_\_\_

## Critical History:

Have You Had Blood Clots? \_\_\_\_\_

If So, Where? \_\_\_\_\_

Are You Refusing Blood Transfusions: \_\_\_\_\_  
For Religious or Other Reasons?

Do You Have or Have You Had Breast Cancer? \_\_\_\_\_

\* Critical for surgical cases . If a breast implant was used in breast reconstruction, it could be ruptured or often the BP can't be taken on the affected side due to post-op arm swelling.

Left Side?: \_\_\_\_\_ Right Side?: \_\_\_\_\_

Do You Have a History of Cardiac Disease or Atrial Fibrillation? \_\_\_\_\_

\* Can increase risk of clot formation.

Have You Had a Cardiac Arrest? \_\_\_\_\_ When? \_\_\_\_\_

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## Critical "Pre-Op" Questions Page 4

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Interpretation of Your EKG? \_\_\_\_\_

Have You Had a Colostomy? \_\_\_\_\_

### Dental History:

Do You Have Full Dentures? \_\_\_\_\_ Partial Dentures? \_\_\_\_\_

Do You Have a Dental Bridge? \_\_\_\_\_ Loose Teeth? \_\_\_\_\_

Do You Have False Teeth? \_\_\_\_\_ Condition of Teeth? \_\_\_\_\_

### Other Medical History:

Do You Have Diabetes? \_\_\_\_\_ Are You Insulin Dependent? \_\_\_\_\_

Type of Insulin? \_\_\_\_\_ Dose? \_\_\_\_\_

How Many Doses Per Day? \_\_\_\_\_ Insulin Pump / Implant? \_\_\_\_\_

Do You Have High Blood Pressure? \_\_\_\_\_

Physical Signed by Physician Within Last 7-Days? \_\_\_\_\_

History of Sickle Cell Anemia? \_\_\_\_\_

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# Critical "Pre-Op" Questions Page 5

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## Infections:

Do You or Family Member Have Creutzfeldt-Jakob Disease (CJD): \_\_\_\_\_

Do You Have an MRSA Infection? \_\_\_\_\_  
(methicillin-resistant *Staphylococcus aureus*)

Do You Have a VRE Infection? \_\_\_\_\_  
(Vancomycin-Resistant *Enterococcus*)

## Other Considerations:

Do You Have Malignant Hyperthermia? \_\_\_\_\_

Do you or a Family Member Have "Trouble" When Under Anesthesia

Are You Pregnant? \_\_\_\_\_

## The Surgery Site:

Is the Paperwork (e.g. Consent Form) Filled Out By the Surgeon? \_\_\_\_\_

Does the Paperwork Clearly Identify the Correct Site? \_\_\_\_\_

Is the Surgery Site Clearly Marked? \_\_\_\_\_

Who Marked the Site?

## The Surgery Site:

Past Surgeries (List Them): \_\_\_\_\_

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Have You Had a Stroke? \_\_\_\_\_

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# Critical "Pre-Op" Questions Page 6

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Describe Your Skin Condition: \_\_\_\_\_

Do You Have a Tampon in Place: \_\_\_\_\_

Do You Have Tattoos / Where? \_\_\_\_\_

\* metallic paint in tattoos can be a site for burns during MRIs or cautery use during surgery

## Implants:

Do You Have an AICD (automatic defibrillator)? \_\_\_\_\_

Do You Have a Central Line , and Where? \_\_\_\_\_

Do You Have Cochlear Implants?

Critical info especially when using this list in surgery since MONOPOLAR bovie can not be used once implant is in

Do You Have a DBS (deep brain stimulator)

Do You Have an EYE / IOL (intraocular "eye" implants ) (\*critical for surgical cases )

If Yes: Left \_\_\_\_\_ Right \_\_\_\_\_

Do You Wear Regular Contacts? \_\_\_\_\_

Are You Using A Feeding Tube? \_\_\_\_\_

Are You Using an Insulin Pump? \_\_\_\_\_ Location \_\_\_\_\_

Are You Wearing Jewelry (regular jewelry, tongue ring, belly button rings, etc.)?

Location: \_\_\_\_\_

Do You Have a Pacemaker? \_\_\_\_\_ Location \_\_\_\_\_

Do You Have Metal Plates? \_\_\_\_\_ Location \_\_\_\_\_

Do You Have Metal Rods? \_\_\_\_\_ Location \_\_\_\_\_

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## Critical "Pre-Op" Questions Page 7

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Do You Have Metal Screws? \_\_\_\_\_ Location \_\_\_\_\_

Do You Have Radioactive Seeds? \_\_\_\_\_ Location \_\_\_\_\_

Do You Have Wires in Sternum? (Wires in breast bone / sternum, placed after a heart by-pass i.e. CABG) \_\_\_\_\_

Critical Lab Values:

- INR: \_\_\_\_\_
- Hgb: \_\_\_\_\_
- Hct: \_\_\_\_\_
- RBC: \_\_\_\_\_
- WBC: \_\_\_\_\_
- Temperature: \_\_\_\_\_
- Blood Type: \_\_\_\_\_

How many units of blood of my type are available? \_\_\_\_\_

Where is the blood? \_\_\_\_\_

Where in your Operating Room is the Emergency Call button located? \_\_\_\_\_

Is there an Anbu Bag present? \_\_\_\_\_

Is it on the patient's bed or stretcher when leaving the OR? \_\_\_\_\_

Is the "Yankeur / Pediatric" suction present, working & ready for use? \_\_\_\_\_

Is the "Attending Anesthesiologists" PIC Number on the erase board? \_\_\_\_\_

Is a "Crash Cart" available? \_\_\_\_\_

Will it also be used in another room? \_\_\_\_\_

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