## Nursing Preoperative Screening

This sample form may be used for nursing preadmission before the day of surgery. This form may be used for telephone or in-person screening and modified per facility policy and procedure.

<table>
<thead>
<tr>
<th>Patient Identification No: ________________________________</th>
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</thead>
<tbody>
<tr>
<td>Patient Name: ___________________ Age: ____ Date of Birth: ____ Today’s Date: ____</td>
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<tr>
<td>Home Address: ________________________________</td>
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<tr>
<td>Gender: ___________________ Height: _______ Weight: _______</td>
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<tr>
<td>Allergies: ____________________________________________</td>
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<tr>
<td>Latex Sensitivity</td>
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<tr>
<td>Advance Directive</td>
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<tr>
<td>Food List</td>
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<tr>
<td>Language Spoken (if other than English): ________________________________</td>
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<tr>
<td>Planned Surgical Procedure: ____________________________________________</td>
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</tbody>
</table>

### Medical History Screening

(Comment on all that apply)

#### Cardiovascular

- Angina
- Arrhythmia
- Congestive heart failure
- Hypertension
- Myocardial infarction
- Pacemaker
- AICD (automatic implantable cardioverter defibrillator)
- Other: ________________________________

#### Respiratory

- Asthma
- COPD (chronic obstructive pulmonary disease)
- Emphysema
- Obstructive sleep apnea
- CPAP (continuous positive airway pressure)
- Recent cold/flu
- Other: ________________________________

#### Hematologic

- Anemia
- Bleeding tendency
- Blood transfusions
- Other: ________________________________

#### Gastrointestinal

- Problems chewing/swallowing
- Gastroesophageal reflux disease
- Hiatal hernia
- Peptic ulcer disease
- Other: ________________________________
Continued . . .

Medical History Screening

Neuromuscular/Musculoskeletal

- Arthritis
- Back/neck problems
- Seizures
- Amputation/prosthesis
- Other: __________________________________________

Miscellaneous

- Diabetes
- Stroke
- Liver disease
- Kidney disease
- Pregnancy
- Last menstrual period
- Communicable disease
- Patient
- Family member

Prior Health Habits (indicate frequency in comments)

- Alcohol
- Caffeine
- Recreational drugs
- Tobacco

Arriving via

- Ambulatory
- Wheelchair
- Stretcher
- Other assistive devices: __________________________________________

Individual who will escort patient home

Name: __________________________________________
Phone number: __________________________________________
Relationship: __________________________________________

Sensory Assessment

- No limitations
- Hearing impairment
- Visual impairment

Comment

Does the patient have any of the following:

- Dentures
- Hearing aid(s)
- Contact lenses

Comment
## Previous Surgeries or Procedures *(describe as applicable)*

<table>
<thead>
<tr>
<th>medication</th>
<th>dose</th>
<th>comments</th>
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</table>

Current pharmacy: __________________________

Information obtained from: □ Patient □ Spouse □ Parent □ Other: __________________________

Nurse completing form: __________________________

Nurse’s signature: __________________________  Date: __________________________

For more information, go to http://www.patientsafetyauthority.org.

This form accompanies the following:

*Patient screening and assessment in ambulatory surgical facilities.*

*Pa Patient Saf Advis*


### References


