

MR# _____
 Name: _____
 BD: _____

UW Hospital
PREOPERATIVE
Telephone or Interview
TRIAGE Tool

Surgeon:	Planned procedure:
Procedure Date:	Work-up Date:
Pt Home Phone:	Pt Work Phone:
Pt Special Needs:	

PATIENT INTERVIEW QUESTIONS		Describe Below
1. Do you take any medications ? (List all meds including aspirin or Advil/Motrin/ ibuprofen in over-the-counter medications) (Bring all medications in labeled containers, or a complete list to clinic)	YES NO	
2. Do you take any vitamins, herbal or “alternative” medications? (please list)	YES NO	
3. Do you have any allergies to medications, foods, or sulfites? 4. Do you have a latex rubber allergy? (**If yes, notify the OR, and patient must come to the Anesthesia Preoperative Clinic!)	YES NO YES NO	
5. Do you, or any family member, have a history of “Malignant Hyperthermia” ? (**If yes, patient must come to the Anesthesia Clinic)	YES NO	

PATIENT INTERVIEW QUESTIONS		Describe Below
6. Have you seen your regular family doctor in the last couple of months? 7. Did he/she do any tests?	YES NO YES NO	
Do you have any heart problems?		YES NO
8. Do you have any of the following: * chest pain, angina, heart attacks? * shortness of breath at any time? * swelling of the ankles or Heart Failure? * irregular heart beats? * heart murmur? *For children with congenital heart disease: do you have “blue spells”?	YES NO YES NO YES NO YES NO YES NO YES NO	
9. Have you had heart surgery or angioplasty (PTCA)?	YES NO	
10. Have you ever had heart tests such as: * exercise stress test (treadmill) or “thallium” scan? * a heart catheterization? * an “echo” heart test? * a “Holter” heart rhythm monitor test?	YES NO YES NO YES NO YES NO	
11. Who can we contact about your treatment? . .		
Do you have any breathing problems? - - - -		YES NO
12. If so, do you have: • emphysema? • wheezing or asthma? • bronchitis? Other?	YES NO YES NO YES NO	

13. Have you had any breathing tests done?	YES NO	
14. Who can we contact about your treatment?		

Have you ever had treatment for cancer? - - -		YES NO	
15. If so, : • What kind of cancer or tumor do/did you have? • Did you have radiation treatments? • Have you had any chemotherapy? *With Bleomycin? *Adriamycin? How much? Did you have any heart tests?	YES NO YES NO YES NO YES NO YES NO		
16. Who can we contact about your treatment?			

Do you see any other specialist doctor for other medical problems? - - - - - Is he/she aware of proposed surgery?	YES NO YES NO	
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TESTS DONE	LIST RESULTS
1. Was CXR done in last year? Pulmonary Function Tests?	Results:
2. Was ECG done in last year? Other cardiac tests?	Results:
3. Blood tests done in last two months?	Results:

TESTS DONE	LIST RESULTS
4. Other Tests: CT, MRI, MRA, Labs, etc.	Results:

PATIENT'S MEDICAL PROBLEM LIST	
1.	5.
2.	6.
3.	7.
4.	8.

Triage Reviewer's Name: _____

Date: _____

..... (Please Print)

Other Notes: