Gramercy Surgery Center PAT Triage Questionnaire

Dear Patient,

This questionnaire will help the Gramercy Surgery Center team determine what, if any, preoperative work up will be needed prior to your surgery and help them gather all available medical information about you. Please fill it out as best you can. This information will help to avoid any delay in your surgery. In some cases, we will contact you to schedule an appointment for a preoperative anesthesia evaluation either in our Manhattan or Queens Center.

If you have any questions, please contact us at **(212)254-3570 *Option 3.**

Patient Name:	DOB:	Height:	Weight:
Date of Surgery:	Surgeon:	Procedure:	
Cell Phone:	Home Phone:	Work Phone:	
Email Address:			
Best Time to Reach You: AM ☐ PM ☐	Best Method to Reach You: Cell ☐ Work ☐ Home ☐ Email ☐		
If you have a PCP (Primary Care Physician), please provide their contact information	Name:	Tel:	

Part 1	**Yes**	**No**
1.) Have you been hospitalized for any reason in the past 6 months? If YES, please explain: ______________________________	☐	☐
2.) Have you gone to the Emergency Room for any reason in the past three (3) months? If YES, please explain: ______________________________	☐	☐
3.) Do you see a medical specialist? If YES, please select which one(s) below:	☐	☐
a. Cardiologist (Heart Doctor) PHONE #: ____________________	☐	☐
b. Pulmonologist (Lung Doctor) PHONE #: ____________________	☐	☐
c. Nephrologist (Kidney Doctor) PHONE #: ____________________	☐	☐
d. Endocrinologist (Diabetes or Thyroid Doctor) PHONE #: ____________________	☐	☐
e. Hematologist (Blood Doctor) PHONE #: ____________________	☐	☐
f. Oncologist (Cancer Doctor) PHONE #: ____________________	☐	☐
Part 2	**Yes**	**No**
4.) Do you have heart problems?	☐	☐
a. Chest Pain	☐	☐
b. Heart Attack	☐	☐
c. Heart Stents	☐	☐
d. Heart Failure	☐	☐
e. Valve Problems	☐	☐
f. Bypass Surgery	☐	☐
g. Irregular Heartbeat	☐	☐
5.) Have you ever had a stroke?	☐	☐
6.) Do you have Sleep Apnea?	☐	☐
7.) Do you have asthma or COPD?	☐	☐

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Part 2 (Continued)	**Yes**	**No**
8.) Do you have a pacemaker or defibrillator?	☐	☐
9.) Do you have kidney failure?	☐	☐
10.) Do you have liver disease?	☐	☐
11.) Do you take blood thinners? If YES, circle which of the following: Coumadin, Pradaxa, Plavix, Effient, Aspirin	☐	☐
12.) Do you have high blood pressure or are you taking medicine for high blood pressure?	☐	☐
13.) Do you have diabetes?	☐	☐
14.) Do you find it difficult to climb a full flight of stairs without stopping to rest?	☐	☐
Part 3 – Physical Activity		
15.) Please describe your regular physical activities (select all that apply):	YES	NO
Light Intensity Activities (< 3)		
a. Sleeping	☐	☐
b. Watching television	☐	☐
c. Writing, desk work, typing	☐	☐
d. Walking, very slow pace	☐	☐
e. Walking, slow pace	☐	☐
Moderate Intensity Activities (3 to 6)		
f. Bicycling, stationary, very light effort	☐	☐
g. Walking, moderate pace	☐	☐
h. Calisthenics, home exercise, light or moderate effort, general	☐	☐
i. Walking, fast pace	☐	☐
j. Bicycling to work or for pleasure	☐	☐
k. Sexual activity	☐	☐
Vigorous Intensity Activities (> 6)		
l. Jogging	☐	☐
m. Calisthenics (e.g. push-ups, sit-ups, pull-ups, jumping jacks), heavy, vigorous effort	☐	☐
n. Running	☐	☐
o. Jumping rope	☐	☐

Form Completed By: ____ Date: ________________