



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 <input type="checkbox"/> PM <input type="checkbox"/>		Best Method to Reach You: Cell <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Email <input type="checkbox"/>		
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: _____			<input type="checkbox"/>	<input type="checkbox"/>
2.) Have you gone to the Emergency Room for any reason in the past three (3) months? If YES, please explain: _____			<input type="checkbox"/>	<input type="checkbox"/>
3.) Do you see a medical specialist? If YES, please select which one(s) below:			<input type="checkbox"/>	<input type="checkbox"/>
a. Cardiologist (Heart Doctor)	PHONE #: _____		<input type="checkbox"/>	<input type="checkbox"/>
b. Pulmonologist (Lung Doctor)	PHONE #: _____		<input type="checkbox"/>	<input type="checkbox"/>
c. Nephrologist (Kidney Doctor)	PHONE #: _____		<input type="checkbox"/>	<input type="checkbox"/>
d. Endocrinologist (Diabetes or Thyroid Doctor)	PHONE #: _____		<input type="checkbox"/>	<input type="checkbox"/>
e. Hematologist (Blood Doctor)	PHONE #: _____		<input type="checkbox"/>	<input type="checkbox"/>
f. Oncologist (Cancer Doctor)	PHONE #: _____		<input type="checkbox"/>	<input type="checkbox"/>
Part 2			Yes	No
4.) Do you have heart problems?			<input type="checkbox"/>	<input type="checkbox"/>
a. Chest Pain			<input type="checkbox"/>	<input type="checkbox"/>
b. Heart Attack			<input type="checkbox"/>	<input type="checkbox"/>
c. Heart Stents			<input type="checkbox"/>	<input type="checkbox"/>
d. Heart Failure			<input type="checkbox"/>	<input type="checkbox"/>
e. Valve Problems			<input type="checkbox"/>	<input type="checkbox"/>
f. Bypass Surgery			<input type="checkbox"/>	<input type="checkbox"/>
g. Irregular Heartbeat			<input type="checkbox"/>	<input type="checkbox"/>
5.) Have you ever had a stroke?			<input type="checkbox"/>	<input type="checkbox"/>
6.) Do you have Sleep Apnea?			<input type="checkbox"/>	<input type="checkbox"/>
7.) Do you have asthma or COPD?			<input type="checkbox"/>	<input type="checkbox"/>



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

Form Completed By: _____ Date: _____