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.**

Patients Name	DOB	Height	Weight
Date of Surgery:	Surgeon:	Procedure:	
Cell Phone:	Home Phone:	Work Phone:	
Email Address:			
If applicable, Health Care Proxy or Guardian name and telephone:			
Primary Care Physician name and number:			

Part 1	**Yes**	**No**
1. Have you been hospitalized or gone to the Emergency Room for any reason in the past 6 months? If YES, please explain: _____	☐	☐
2. Have you had any changes to your health in the last 6 months? If YES, please explain: _____	☐	☐
3. Do you see any medical specialists? If YES, please select which one(s) below:	☐	☐
Cardiologist (Heart) T# _____ Pulmonologist (Lung) T# _____ Nephrologist (Kidney)T# _____ Other: _____		
4. Are you currently taking any medications? a. If YES, are you taking these diabetic/weight loss medications: ☐ SGLT2 inhibitors? ☐ GLP1 Agonists? b. If YES, have you had any changes to your medications in the last 6 months? ☐ YES ☐ NO c. Please list all medications you are currently taking, if any: _____ _____	☐	☐
5. Do you have heart problems?	☐	☐
a. Chest Pain If YES, date last occurred:	☐	☐
b. Heart Attack If YES, date last occurred:	☐	☐
c. Heart Stents If YES, date last occurred:	☐	☐
d. Bypass Surgery If YES, date last occurred:	☐	☐
e. Valve Problems	☐	☐
f. Heart Failure	☐	☐
g. Irregular Heartbeat	☐	☐
6. Have you ever had a stroke? If YES, date last occurred:	☐	☐
7. Do you have a pacemaker or defibrillator?	☐	☐
8. Have you had any prior surgeries? If YES, please list any previous surgeries: _____	☐	☐

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Part 2	**Yes**	**No**
9. Do you have Sleep Apnea? If YES, do you use a sleep apnea (CPAP) machine? ☐ YES ☐ NO	☐	☐
10. Do you have any history of head and neck surgery and/or radiation?	☐	☐
11. Do you have asthma or COPD? If YES, do you use home oxygen? ☐ YES ☐ NO If using an inhaler, how often? ☐ <2 days per week ☐ Once a day ☐ Throughout the day If YES, have you had an ER visit or used steroids within the last one year? ☐ YES ☐ NO	☐	☐
12. Personal or family history of malignant hyperthermia?	☐	☐
13. Do you have a history of a seizure disorder or other significant central nervous system disease (i.e MS)?	☐	☐
14. Do you have kidney failure? If YES, do you require any type of dialysis? ☐ YES ☐ NO	☐	☐
15. Do you have liver disease?	☐	☐
16. Do you take any blood thinners OTHER than Aspirin? Ex. Coumadin, Pradaxa, Plavix, Effient	☐	☐
17. Do you have high blood pressure or are you taking medicine for high blood pressure?	☐	☐
18. Do you have diabetes? If YES, do you take insulin? ☐ YES ☐ NO	☐	☐
19. Do you have trouble lying flat (1 pillow) for 45 minutes? If YES, please select a reason: ☐ Can't breathe ☐ Back Pain	☐	☐
20. Do you have any additional significant medical conditions? If YES, please specify: _____	☐	☐

Part 3			
21. In the last month, have you been able to perform ANY ONE of the group activities?	METS	Yes	No
A. Sitting, reading, watching TV, listening to music	1	☐	☐
B. Walking indoors, such as around the house or dressing/undressing	2	☐	☐
C. Descending stairs, making beds, vacuuming, sweeping the floors, walking the dog for pleasure, play with children at moderate effort	3	☐	☐
D. Stair climbing slowly, hanging laundry, cleaning the bathroom, mowing/raking the lawn or sweeping the outside , leisure bicycling, walking for exercise	4	☐	☐
E. Moving furniture or household items, lifting light loads, playing/running with children or animals at vigorous effort, recreational swimming	5	☐	☐
F. Hiking cross country, biking to/from work at self-selected pace, scrubbing floors on hands and knees with vigorous effort, shoveling snow	6	☐	☐
G. Carrying groceries upstairs, jogging, recreational swimming	7	☐	☐
H. Stair climbing at a rapid pace, carrying upstairs a suitcase (20-40lb/10-20kg), running	8	☐	☐

Form completed by: _____ **Date:** _____