

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	W	/eight		
Date of Surgery	:	Surgeon	ı: T		Proced	ure:			
Cell Phone:			Home Phone:			Work Phone:			
Email Address:									
If applicable, He	ealth Care Proxy or Gu	ardian nan	ne and telephone:						
Primary Care Ph	nysician name and num	iber:	•						
Part 1								Yes	No
1. Have yo	ou been hospitalized or	gone to th	e Emergency Room for ar	ny reason in t	he past 6	months?			
If Y	YES, please explain:								
	ou had any changes to y							1	
_									
-			ES, please select which or						
	•		Pu						
			Oth	er:					
4. Are you	currently taking any r								
a.	If YES, are you taking	ng these di	abetic/weight loss medica	tions: So	GLT2 inh	nibitors? GLP1 A	gonists?	'	
b.	If YES, have you ha	d any chan	iges to your medications in	n the last 6 m	onths?	YES	NO		
c.	Please list all medica	ations you	are currently taking, if any	/:					
-	have heart problems?								
a.	Chest Pain		date last occurred:						
b.	Heart Attack		date last occurred:						
c.	Heart Stents		date last occurred:						
d.	Bypass Surgery	If YES, o	date last occurred:						
e.	Valve Problems								
f.	Heart Failure								
g.	Irregular Heartbeat								
6. Have yo	ou ever had a stroke?	If YES, d	ate last occurred:						
7. Do you have a pacemaker or defibrillator?									
8. Have you had any prior surgeries?									
If YES, please list any previous surgeries:									



Gramercy Surgery Center PAT Triage Questionnaire

Patient Name:	DOB

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 szizure 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 have liver disease? 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 mouth, have you been able to perform ANY ONE of the group activities? METS No METS Yes No Disting reading, watching TV, listening to music B. Walking indoors, such as around the house or dressing/undressing C. Descending stairs, making beds, vacuuming, sweeping the floors, walking the dog for pleasure, play with children at moderate effort C. Descending stairs, making beds, vacuuming, sweeping the floors, walking the dog for pleasure, play with children at moderate effort D. Shair climbing slowly, langing laundry, cleaning the bathroom, mowing/raking the lawn or sweeping the outside, leisure bicycling, walking for exercise E. Moving furniture or household items, lifting light loads, playing/running with children or animals at vigorous effort, storeding snow G. Carrying groceries upstairs, jogging, recreational swimming G. Carrying groceries upstairs, jogging, recreational swimming	Part 2		Yes	No	
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H. Stair clinibing at a rapid pace, carrying upstairs a suitcase (20-400/10-20kg), running	H. Stair climbing at a rapid pace, carrying upstairs a suitcase (20-40lb/10-20kg), running 8				

Form completed by:	Date:	