THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Preoperative Assessment Center (OPAC)

Patient Name:_____

Date of Birth:_____

Check the "YES" box if you have had or currently have any of the following

YES	Anesthesia / Airway
	Severe nausea or vomiting after surgery
	Difficult insertion of breathing tube
	Malignant hyperthermia (you or your family)
	Blood relative, complication with anesthesia
	Anesthesia administered before
	Difficulty drawing blood or starting I.V.
	Would you accept a blood transfusion? If no, why not
YES	**Cardiovascular**
	Heart attack
	High Cholesterol
	Congestive heart failure
	Coronary artery disease
	Born with a heart problem
	Heart murmur
	High blood pressure
	Irregular heart beat
	Heart valve problem
	Pacemaker or defibrillator
	Cardiac stent
	Heart surgery
	Heart Catheterization/Angioplasty
	Heart attack
YES	**Pulmonary**
	Emphysema
	History of pneumonia
	Chronic Bronchitis
	Asthma
	Tuberculosis
	Use oxygen
	COPD
	Sleep apnea
	Use CPAP

YES	Sleep Apnea Risk
	Snore loud enough to be heard through closed door
	Frequently feel tired during the day
	Gasp for air or choke while you sleep
YES	**Clotting / Bleeding**
	Blood clot in legs or arms (DVT)
	Blood clot in lungs (PE)
	Had a blood transfusion in the past
	Anemia
	Taking blood thinners
	Blood clotting disorder
YES	**Diabetes**
	Treated with:
	Diet
	Pills
	Insulin
YES	**Past Medical History**
	Glaucoma
	MRSA or VRE
	Hepatitis
	Acid reflux / GERD
	Stomach ulcer
	Degenerative arthritis
	Osteoporosis
	Rheumatoid arthritis
	Personal history of cancer
YES	**Your Doctors (name and phone number)**
	Family:
	Heart:
	Lung:
	Cancer:
	Surgeon:
	Other:

	Dialysis
	Kidney disease
	Seizures / Epilepsy
	Stroke or TIA
	Radiation therapy
	Chemotherapy
	HIV
	Thyroid disease
	TMJ

(over)

Check the "YES" box if you currently have any of the following

YES	Constitutional	YES	Neurological	YES	Endocrine
	Fever / Chills		Dizziness		Hot flashes
	Fatigue /feel tired during the day		Headache		Night sweats
	Weight gain (more than 5 lbs)		Tingling	YES	**Social History**
	Weight loss (more than 5 lbs)		Tremor		Cigarette smoking
YES	**Skin**	YES	**Psychiatric**		Packs per day:
	Itching/dry		Depression		Years of smoking
	Open sores		Insomnia		Quit – When?
	Recent rash		Memory loss		Cigar or pipe smoking
YES	**HENT**		Anxiety		Smokeless tobacco
	Hearing loss	YES	**Lymph / Heme**		Use of illicit drugs
	Ringing in ears		Bruise easily		Date last used:
	Sinus problems		Bleed easily		Alcohol - Drinks per day:
	Stuffy nose or runny nose				Treated for alcoholism
	Sore throat				Body Piercings

YES	Eyes	YES	Allergy / Immunology	
	Blurred vision		Latex	
	Double vision		Food:	
YES	**Cardiovascular**		Medications:	
	Chest pain / chest pressure			
	Pain in calves when walking			
	Shortness of breath with activity			
	Swelling in feet or ankles			
	Difficult breathing lying down			
	Palpitations – skip beat or flutter	YES	**Past Surgical History**	
YES	**Respiratory**		Date	Type of Surgery
	Current cough / regularly cough			
	Shortness of breath at rest			
	Wheezing			
YES	**Gastrointestinal**			
	Abdominal pain			
	Constipation			
	Diarrhea			
	Nausea			
	Vomiting			
	Trouble swallowing			
	Heartburn			
YES	**Genitourinary**			
	Burning or pain urinating			
	Blood in urine			
	Frequent urination			
YES	**Musculoskeletal**			
	Back pain			
	Recent falls			
	Neck pain			