Lenox Health Greenwich Village
Northwell Health

Name _____

DOB _____ Height _____ Weight _____ BMI _____

Telephone Number _____

Preferred Language _____

Emergency Contact _____

Relationship _____ Number _____

Last Menstrual Period _____

Primary Medical Doctor (Name & Number) _____

_____

Cardiologist (if applicable) _____

_____

Allergies (Including food, latex, dyes) _____

_____

List all meds that you take regularly (use attached sheet) ☐ None

_____

_____

Do you take Aspirin/blood thinners? ☐ No ☐ Yes

Name _____ Last Taken _____

Do you smoke? ☐ No ☐ Yes, how many packs per day? _____

How often do you drink? Seldom ☐ Socially Heavily

List all operations that you've had and year of surgery

_____

_____

Have you been hospitalized for any medical conditions?

☐ No ☐ Yes, Explain _____

_____

Have you had any problems with anesthesia in the past?

Describe _____

Any anesthetic problems in your family _____

	Yes	No
Do you have any loose teeth dentures or caps?	☐	☐
Do you wear contact lenses?	☐	☐
Past history of drug abuse?	☐	☐
Do you have high blood pressure?	☐	☐
Do you get chest pain (angina)?	☐	☐
Have you had a heart attack or congestive heart failure?	☐	☐
Do you get palpitations?	☐	☐
Have you ever had rheumatic fever?	☐	☐
Do you have a heart murmur?	☐	☐
Do you have a pacemaker/AICD?	☐	☐

Place Patient Label Here

	Yes	No
Do you get short of breath if you do not sleep on 2 or more pillows?	☐	☐
Have you had a recent cough, cold, fever, or infection?	☐	☐
Do you have asthma, bronchitis, emphysema, or history of pneumonia?	☐	☐
Do you have stomach problems (ulcer or heartburn)?	☐	☐
Do you have a hiatal hernia?	☐	☐
Have you ever been treated for anemia?	☐	☐
Do you have sickle cell anemia or trait?	☐	☐
Do you bruise or bleed easily?	☐	☐
Have you ever had a blood transfusion?	☐	☐
Have you ever had kidney failure, stones, or infections?	☐	☐
Do you have thyroid disease?	☐	☐
Are you diabetic?	☐	☐
Do you have liver disease (cirrhosis or hepatitis)?	☐	☐
Do you have arthritis of your jaw, neck, or back?	☐	☐
Do you have difficulty opening your mouth?	☐	☐
Any history of seizures?	☐	☐
Have you ever had a stroke or temporary black out?	☐	☐
Have you had a significant weight loss in the last 6 months without dieting?	☐	☐
Do you have or have been diagnosed with Sleep Apnea?	☐	☐
If yes, do you use CPAP?	☐	☐
Do your calves get cramps when you walk a short distance?	☐	☐

If you answered yes to any question, please explain below:

_____

_____

_____

_____

_____

Escort (Adult > 18 yrs old) Name Number

_____

Patient or person completing form Date

Notes _____

_____

_____

_____

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Medication Name	Dose (i.e. mgs) Frequency	Reason Taking

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Preoperative STOP BANG Questionnaire for Obstructive Sleep Apnea

This tool is to be completed during the preoperative interview to assess the potential for obstructive sleep apnea (OSA). Answers to these questions will assist anesthesia in identifying the risk and possible need for Pulmonary Clearance and/or Sleep Study prior to surgery.

Please check here if you have already been diagnosed with sleep apnea ☐

	Yes	No	
1.	☐	☐	**Snoring:** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
2.	☐	☐	**Tiredness/Fatigue:** Do you often feel tired, fatigued or sleepy during the daytime, even after a good night's sleep?
3.	☐	☐	**Observed apnea:** Has anyone ever observed you stop breathing during your sleep?
4.	☐	☐	**Pressure:** Do you have or are you being treated for high blood pressure?
5.	☐	☐	**Body Max Index: Is the patient's weight a BMI of 35 or higher?**
6.	☐	☐	**Age:** Are you older than 50 years of age?
7.	☐	☐	**Neck Size: Does your neck measure more than 15 ¾" for women and 17" for men?**
8.	☐	☐	**Gender:** Are you a male?

Please check the Risk below:

☐	Low Risk of OSA:	Yes to 0-2 questions
☐	Intermediate Risk of OSA:	Yes to 3-4 questions
☐	High Risk of OSA:	Yes to 5-8 questions

Completed by: _____ Date: _____ Time: _____