Preoperative Medical and Surgical History Questionnaire

Please read the document carefully and tick the boxes that apply to you.

Tick ONLY the boxes that you answer YES to.

This checklist ensures that we have a complete understanding of your medical history, which is essential for safe and effective preoperative planning. It also protects both you and our team by documenting critical health information that could impact the outcome of your procedure. Providing accurate and thorough responses will help us minimize risks and address any potential complications proactively. Provide us a copy and keep one in your file and keep one with you at all times so you can show it to the Anesthesiologist/Cardiologist for their review.

1. Medical History

□ Do you have diabetes (Type I or II)?

- **If yes, please specify:** _____

□ Do you have high blood pressure (hypertension)?

- **If yes, please specify your normal blood pressure range:** _____

□ Have you been diagnosed with any heart diseases (e.g., arrhythmias, ischemic heart disease)?

- **If yes, please specify:** _____

□ Do you have any lung problems (e.g., COPD, asthma)?

- **If yes, please specify:** _____

□ Do you have kidney problems (e.g., chronic kidney disease)?

- **If yes, please specify:** _____

□ Do you have any liver conditions (e.g., cirrhosis, hepatitis)?

- **If yes, please specify:** _____

□ Have you been diagnosed with any thyroid or other endocrine problems?

- **If yes, please specify:** _____

□ Do you have any rheumatologic conditions (e.g., rheumatoid arthritis, gout)?

- **If yes, please specify:** _____

□ Do you have any blood disorders (e.g., anemia, clotting disorders)?

- **If yes, please specify:** _____

□ Have you ever had deep vein thrombosis (DVT) or a pulmonary embolism?

- **If yes, please specify:** _____

□ Have you ever had a seizure or stroke?

- **If yes, please specify:** _____

□ Do you have nerve-related problems (e.g., diabetic neuropathy)?

- **If yes, please specify:** _____

□ Have you ever had tuberculosis or HIV?

- **If yes, please specify:** _____

□ Have you recently experienced any skin or systemic infections?

- **If yes, please specify:** _____

□ Do you have any allergies (e.g., medications, latex, or metals)?

- **If yes, please specify:** _____

2. Surgical History

□ Have you had any prior surgeries on your knee(s)?

- **If yes, please specify the type and date:** _____

□ Have you had any other orthopedic procedures?

- **If yes, please specify:** _____

□ Have you had any non-orthopedic surgeries?

- **If yes, please specify:** _____

□ Have you ever experienced complications during or after surgery (e.g., infections, anesthesia reactions)?

- **If yes, please specify:** _____

3. Lifestyle Factors

□ Do you currently smoke?

- **If yes, how many cigarettes per day and for how many years?**

  _____

□ Have you smoked in the past?

- **If yes, when did you quit?** _____

□ Do you drink alcohol?

- **If yes, how often and how much?** _____

□ Have you ever had issues with alcohol dependency or abuse?

- **If yes, please specify:** _____

□ Do you use recreational drugs or misuse prescription medications?

- **If yes, please specify:** _____

4. Medications

□ Are you currently taking any anticoagulants (e.g., warfarin, NOACs)?

- **If yes, please specify:** _____

□ Are you currently taking any antiplatelet medications (e.g., aspirin, clopidogrel)?

- **If yes, please specify:** _____

□ Are you on long-term steroid therapy?

- **If yes, please specify:** _____

□ Do you regularly take NSAIDs or pain relievers?

- **If yes, please specify:** _____

□ Are you taking any immunosuppressants?

- **If yes, please specify:** _____

□ Do you take any herbal or over-the-counter supplements?

- **If yes, please specify:** _____

5. Social and Family History

□ Does anyone in your family have a history of blood clots (DVT) or bleeding disorders?

- **If yes, please specify:** _____

□ Does your job or daily activities involve heavy physical demands?

- **If yes, please specify how much are the physical demands:**
  _____

□ Do you have someone who can assist you during recovery at home?

- **If yes, please specify who:** _____

6. Other Considerations

□ Do you have any mental health conditions (e.g., depression, anxiety)?

- **If yes, please specify:** _____

□ Have you experienced significant weight loss or gain recently?

- **If yes, please specify:** _____

□ Do you have any nutritional deficiencies or malnourishment issues?

- **If yes, please specify:** _____

□ Are you currently pregnant or breastfeeding?

- **If yes, please specify:** _____

I hereby declare that the information I have provided in this document is accurate, complete, and truthful to the best of my knowledge. I understand that this information is critical for my preoperative assessment and care, and any omission or misrepresentation of relevant details may impact my treatment outcomes. I also acknowledge that this document will form part of my medical record and may be used for legal and medical reference if unforeseen complications arise.

_____

Patient Name and Signature