ERNEST L. SINK, M.D.
Pediatric and Young Adult Hip Surgery
Center For Hip Preservation
Hospital for Special Surgery
Tel: 212.606.1268 / Fax: 212.606.1685

Medical Questionnaire

Name: ________________________ Age: ___ Sex: M/F DOB: __/__/__ Height: ___ Weight:___
Primary Care Physician: ________________ Phone No: ___-___-___
Expected Procedure: R/L Surgical Hip Dislocation / PAO DOS: __/__/__
Telephone to be Reached Prior to Surgery: ___-___-___
Pharmacy Information: Name: __________ Tel ___-___-___ Address: ______________________

Allergies: ☐Yes ☐No ☐Food ☐Drug ☐Latex ☐Other

ALLERGEN	REACTION

Medications: Maintenance and As Needed

NAME	INDICATION/DOSE

Medical History:

Disease	Date Diagnosed	Treatment

Surgical History:

Disease	Date of Procedure	Name of Procedure

Anesthesia: ☐General ☐Regional ☐ Spinal ☐Epidural ☐Local ☐None ☐ Unsure

Complications/Problems experienced with anesthesia:

Prior Hospitalizations including Emergency Room visits:

Reason	Date

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Health Assessment Data Form: Do you have or ever had any of the following?	No	Yes	Consult Required:
Heart:			
Atrial fibrillation/irregular heartbeat/palpitations/mitral valve prolapse			
High blood pressure/high cholesterol			
Chest pain/Shortness of breath with activities			
Heart attack/heart failure/heart surgery			
Any cardiac procedures: (Stress test/pacemaker/cath)			
If so: Date __/__/__ Where:			
Do you take antibiotics prior to any surgical or any dental work?			
Breathing:	No	Yes	Consult Required:
Shortness of breath/swollen ankles/need to sit up			
Smoked in the last year/smoked 1-2ppd for >/= 10 yrs			
Oxygen use or any breathing machine at home			
Severe emphysema/asthma/bronchitis that limit activities			
Embolus or clot in the lung			
Sleep apnea			
Snore/snort/gasp/choke/stop breathing while asleep			
Blood Disorders:			
Anemia/low blood count			
Any type of bleeding/clotting disorder			
Bruise easily			
Blood clot or embolus in the legs or other organs			
Use blood thinners:			
Metabolic/Kidney:			
Diabetes: Type:			
Adrenal/thyroid disease			
Kidney disease/kidney failure/dialysis/			
Elevated kidney function test			
Hepatitis/jaundice/liver failure			
Use of diuretics			
Gastrointestinal:			
Severe abdominal pain			
Gastroesophageal reflux			
Loss of appetite or unintentional weight loss in the past yr			
Neurological/Musculoskeletal:			
Stroke/TIA/Seizures			
Numbness/tingling/weakness in arms or legs			
Head/neck/back injuries			
Chronic pain			
Use of narcotic pain medications or pain pump at home			
Collagen disease/Lupus/Rheumatoid Arthritis/Raynauds			
Obsterics:			
Are you or might be pregnant?			

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Health Assessment Data Form: Do you have or ever had any of the following?	No	Yes	Consult Required:
LMP: __/__/__			
Cancer:			
History of cancer/received radiation/chemotherapy			
Biopsy: Which body part/side: _____ Left/Right			
Eyes:			
Dry eyes/glaucoma/cataract			
Behavioural Health:			
Anxiety/depression or psychiatric disorder			
Blood Transfusion:			
Blood transfusion in the last 3 months			
Reaction or allergy to blood transfusion			
Communicable Disease:			
Herpes/AIDS/HIV/SARS			
Have you traveled outside the US in the last month?			
If yes, where?			
Anesthesia:			
Problems with placement of breathing tube			
Surgery in the lungs/throat/vocal cords			
Trouble opening mouth/bending neck forward/backward			
Anesthesia consult request before the day of surgery			
Pre-operative Medical Clearance Requirement/Order (Clinical Staff Only)			
Medical Clearance Required: EKG/Chest XRay/Bloodwork: Chem7, CBC w/diff, Coags/bHCG			
Specialist Required			
Radiation Therapy Required on post-operative day 1			
Blood Donation: __ Autologous __ Directed			
Blood Bank request for T&S/T&C/Number of units			

__________________________________, M.D.
Reviewed by: Ernest L. Sink