The Center for Specialized Surgery

PRE-OPERATIVE INFECTION SCREENING TOOL

Do you currently have any respiratory symptoms (cough, congestion, fever, etc)?	☐ Yes	☐ No
If yes, describe:		
Do you have any skin rashes, sores or wounds?	☐ Yes	☐ No
If yes, describe:		
Have you been recently exposed to a communicable disease?	☐ Yes	☐ No
If yes, explain (if disease is known, please specify)		
Have you ever had a post-operative infection or history of MRSA?	☐ Yes	☐ No
If yes, explain?		
Do you have an infection anywhere?	☐ Yes	☐ No
If yes, describe:		
Have you been on any antibiotics within the last 30 days?	☐ Yes	☐ No
If yes, which antibiotic and for what?		
Have you or anyone in your immediate household traveled outside of the U.S. in the last 30 days?	☐ Yes	☐ No
If yes, where and when? Any fever (101.5 or greater), headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain, or unusual bleeding?		