Hôpital Régional de Pembroke Regional Hospital

Patient Questionnaire, Pre-Operative Assessment Clinic Adult

Addressograph

Dear Patient: *Please complete this questionnaire to the best of your ability and give it to your surgeon's office team. If you are not sure of any answer, check "Not Sure". You can add details in the "Comments" box. Please write your name on each page as the questionnaire will be unstapled and scanned into your medical record.*

Name:	Telephone: (Home & Cell)		□ Male □ Female
Date of Birth: (yyyy/mmm/dd)	Age:	Weight (kg):	Height (cm):
Family Physician:	Surgeon's Name:		

Do you have any drug allergies or sensitivities?
□ No □ Yes, specify:

Name of allergen	Reaction

List all current prescription medications including inhalers. Attach list if necessary:

Do you have a latex allergy? □ No □ Yes, specify:

Have you had any previous surgery involving anesthetic? □ No □ Yes, please specify with approximate dates:

Have you had any problems with local, spinal, epidural, or general anesthetic? □ No □ Yes, please specify:

Have you or your family (blood relatives) had serious problems following an anesthetic other than nausea or vomiting (e.g. malignant hyperthermia or pseudocholinesterase deficiency)? □ No □ Yes, specify:

Do you have any removable dental appliances like dentures or bridges? □ No □ Yes, specify:

BREATHING

	Yes	No	Not sure	Comments
Are you currently a smoker?				*If yes, then specify:* *Number/day:* *Number of years:*
If not currently a smoker, have you smoked tobacco of any kind in the past? Please indicate which (e.g. cigarettes, cigars, pipes, marijuana).				*Date that you quit:* *Number of smoking years:*
Do you have emphysema, chronic obstructive pulmonary disease (COPD), or chronic bronchitis?				
Do you have asthma?				
If asthmatic, do you need your relief medication (blue puffer) more than twice per week, or have you needed oral steroids in the last two months?				
Do you use inhalers (puffers)?				*How often?*

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BREATHING, cont.	Yes	No	Not Sure	Comments
Do you use oxygen at home to help you breathe?				
Do you have a problem lying flat for at least 30 minutes because of difficulty breathing?				
Have you had shortness of breath for which you have been admitted to hospital within the last two months?				
Do you have sleep apnea?				
Were you prescribed a machine to help you breathe at night?				*Do you use it every night?* □ *Yes* □ *No, specify:*

HEART				
Do you have:	**Yes**	**No**	**Not sure**	**Comments**
Any heart problems (e.g. heart attack, murmur, angina, blockages, angioplasty, stent, valve problems, irregular heartbeat, heart surgery, heart failure)?				*Specify:*
High blood pressure or take medication for high blood pressure?				
Chest pain or breathlessness after climbing 1 flight of stairs?				
A pacemaker or an implantable defibrillator? Circle which one.				*Date last checked?*
Do you take Aspirin (ASA) regularly?				*Why?*
A prescription for blood thinners (e.g. warfarin, coumadin, Plavix, clopidogrel, dabigatran, rivaroxaban, apixaban, eliquis)?				*Why?*
An artificial heart valve?				
Any other heart issues?				*Specify:*

BLOOD SUGAR AND BLOOD PROBLEMS				
Do you have or have you been treated for:	**Yes**	**No**	**Not sure**	**Comments**
Diabetes?				□ *Insulin* □ *Diabetic Pills* □ *Diet Controlled*
Anemia (low blood count)?				
A bleeding disease or problem?				*Specify:*

NEUROLOGICAL AND MUSCULAR				
Do you have/ have you had:	**Yes**	**No**	**Not sure**	**Comments**
Significant memory problems or dementia?				
A history of extreme confusion after an operation?				
A disease that affects your muscles and nerves like muscular dystrophy, ALS, multiple sclerosis, etc.?				
A stroke or mini-stroke/TIA?				
Back surgery or metal in your back?				
Epilepsy or convulsions?				*Approximate date of last seizure:*

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NEUROLOGICAL AND MUSCULAR, cont.	Yes	No	Not sure	Comments
Fainting spells in the last year?				
Rheumatoid or any inflammatory arthritis?				
OTHER IMPORTANT MEDICAL INFORMATION				
	Yes	**No**	**Not sure**	**Comments**
Do you have a history of anxiety, depression, or Post-Traumatic Stress Disorder?				
Do you have trouble opening your mouth, jaw, or moving your neck to look at the ceiling?				
Do you take prescribed medications (e.g. codeine, morphine, hydromorphone, tramadol, etc.) or substances not prescribed by a physician (e.g. marijuana, heroin, cocaine, etc.) for chronic pain or recreation?				
Have you taken oral steroids (e.g. prednisone) in the past year?				
Could you be pregnant?				*How many weeks?*
Do you have kidney disease?				*Specify:*
Do you have thyroid disease?				□ *Not well controlled* □ *Well controlled*
Are you HIV positive?				
Do you have liver disease (Hepatitis)?				*Specify:*
Do you have an autoimmune disease (e.g. lupus, Crohn's)?				
Do you have, or have you had, cancer?				*What type?*
Have you had radiation treatment?				□ *To the head or neck* □ *Other, specify:*
Male patients: On average, do you drink more than 3 alcoholic drinks per day or 21 drinks per week? **Female patients:** On average, do you drink more than 2 alcoholic drinks per day or 14 drinks per week?				*Total per week:*
Do you have acid reflux that is not well controlled?				
Do you have a hearing impairment or wear a hearing aid?				
Do you have any other illness, limitations, or concerns we should know about?				*Specify:*
Pre-Operative Assessment Clinic Patient Questionnaire completed by: □ **Patient** □ **Family Member** □ **Health Care Provider** □ **Other, specify:**				

OFFICE USE ONLY

Reviewed by:

Print Name(s): _____ **Signature:** _____ **Date:** **(yyyy/mmm/dd)** _____

Print Name(s): _____ **Signature:** _____ **Date:** **(yyyy/mmm/dd)** _____