Preoperative Assessment Patient Questionnaire

Addressograph Label
Client Label
DOB mm/dd/yyyy
PHIN/MHSC#
HRN

Please complete this form to help our Health Care Team meet your medical needs.
Please return this form to your surgeon's clinic. This information is needed at least **3 weeks** before your or your surgery may be delayed.

1.	Legal Name: _____ _____ _____ *Surname* *Middle Initial* *First* Contact Number: Alternate:	***Hospital Use only Interview Information***
2.	Date of Surgery: _____ Surgeon's Name:_____ Type of Surgery: _____	T_____P_____RR
3.	Do you have a Health Care Directive ☐ No ☐Yes ☐Copy attached Power of Attorney:_____ Contact No;_____	BP _____ ☐ RT ARM ☐ LT ARM
4.	What Language do you speak: ☐ English ☐ French ☐Other:_____ Will you need an interpreter? ☐ No ☐Yes	0_2 SATS _____ Weight_____ Height_____ BMI_____
5.	Contact Person_____Relationship:_____ Contact Number:_____	
6	Who will pick you up from the hospital ☐Same as above ☐Other: Contact Person_____Relationship:_____ Contact Number:_____	ASA (circle) **I II III IV V**
7	Have you been hospitalized for more than 24 hours or spent more than 24 hours in an Emergency Department in the past 6 months? ☐ No ☐Yes	☐Surveillance swab sent (if indicated)
8	Have you been hospitalized or investigated for the following in the past 6 months? ☐ No ☐Yes ☐C.difficile ☐MRSA ☐Tuberculosis (TB) ☐Other:_____☐Do not know	
9	Do you have allergies and/or intolerances (e.g. medication, latex, tape, dust/pollen, food, etc.)? ☐ No ☐Yes (list below)	
10	**Do you wear a Medic Alert® Bracelet?** ☐ No ☐Yes What does it say?	
11	List home medications or attach a copy of your medication list Prescription medications e.g.: birth control pills, creams, eye drops, inhalers, insulins, patches, sleeping pills, etc.) Over the counter medications (e.g. aspirins, cold/allergy drugs, laxatives, vitamins, herbs or others (e.g.:	Medication Reconciliation completed for same day admission. Best Possible Medication History completed for day surgery patient with chronic renal failure on hemodialysis.

Allergic to:	**Reaction:**

Drug Name	Dose (Grams or MG)	How often	Reason

If you are coming to the Preoperative Assessment Clinic, please bring the containers of all prescription and over the counter medications with you.

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12	**Family Doctor's Name**: _____Phone number: _____ Date of last visit: _____ Reason:_____	***Hospital Use only*** ***Interview Information***
13	**Do you see a Specialist Doctor** (heart, lung, blood, etc.) ☐ No ☐Yes (list below) * Doctor's Name _____ Phone number: _____ Date of last visit: _____ Reason:_____ * Doctor's Name _____ Phone number: _____ Date of last visit: _____ Reason:_____ * Doctor's Name _____ Phone number: _____ Date of last visit: _____ Reason:_____	
14	**Is it possible that you could be pregnant?** ☐ No ☐Yes	
15	**Do you have Obstructive Sleep Apnea (OSA)?** ☐ No ☐Yes Have you had a sleep study? ☐ No ☐Yes Do you use a CPAP / BiPAP machine? ☐ No ☐Yes Do you snore loudly (enough to be heard through closed doors)? ☐ No ☐Yes Do you think you have abnormal or excessive sleepiness during the day? ☐ No ☐Yes Has anyone noticed that you momentarily stop breathing during your sleep? ☐ No ☐Yes Is your neck measurement greater than 40 cm / 16 inches? ☐ No ☐Yes	Known OSA (PAC referral required) If questions 17 b-g are Yes (PAC referral required)
16	Do you get short of breath or tightness in your chest lying flat in bed or getting dressed? ☐ No ☐Yes Can you climb 1 flight of stairs without stopping to rest? ☐ No ☐Yes ☐Haven't tried this activity	
17	Health History: Place a mark (X) if you have had any of these. ☐ None	

☐Chest Pain	☐ Parkinson's Disease/tremors	☐ Anemia/low iron
☐Angina/Heart Related Chest Pain	☐ Muscle disease	☐ Chronic Pain
☐ Heart Attack	☐ Joint/bone problems (arthritis)	☐ Gout
☐ Congestive Heart Failure	☐ Frequent heart burn/acid reflux	☐ Bleeding disorders
☐ Heart Murmur	☐ Lung Problems	☐ Sickle Cell Disease
☐ Heart bests faster, Skipped beats	☐ Shortness of breath, cough	☐ Ulcers
☐ Rheumatic fever	☐ Asthma	☐ Open wounds
☐ High Blood Pressure	☐ Wheeze	☐ Skin rashes
☐ Implanted electronic devices (pace-maker, internal defibrillator, internal pain stimulator) Date of last visit: (DD/MM/YYYY)	☐ Home oxygen	☐ Migraines/headaches
	☐ Hepatitis/Jaundice/Liver Disease	☐ Glaucoma
	☐ Bowel disease (Crohn's Colitis)	☐ Thyroid problems
☐ Persistent swelling in legs and/or feet	☐ Kidney/bladder problems	☐ Mental health issues
☐ Transient Ischemic attack (TIA) mini stroke	☐ Hemodialysis: Date of last treatment (DD/MM/YYYY)_____	☐ Dementia
☐ Blackouts/fainting spells in last year		☐ Anxiety/panic attacks
☐ Blood transfusion Date: (DD/MM/YYYY)	☐ Peritoneal dialysis: date of next treatment:	☐ Diabetes
☐ Seizures	☐ Pseudo cholinesterase Deficiency	☐ Cancer
☐ Blood clots: (legs, lungs, pelvis)	☐ Disease of nervous system (MS)	☐ AIV/AIDS
☐ Family history of Blood clots	☐ Malignant Hyperthermia	☐ Recent Memory loss
☐ Stroke	☐ Other:	

Comments:_____

_____

_____

_____

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18	**Are there health problems that run in your family?** ☐ No ☐Yes Explain:_____ Have you ever had an anesthetic? ☐ No ☐Yes Have you ever had a problem with anesthetic? ☐ No ☐Yes Explain:_____ Has anyone in your family ever had a problem with an anesthetic? ☐ No ☐Yes Explain:_____	***Hospital Use only*** ***Interview Information***

19 **List any operations (surgery) you have had:**

Operation	Date (DD/MM/YYYY)	Hospital

20 **The last time you had surgery:**
Did you experience confusion, hallucination or behavior that was unusual for you? ☐ No ☐Yes
Have you been admitted to hospital for any reason other than surgery? ☐ No ☐Yes

Reason	Date (DD/MM/YYYY)	Hospital

21 **List any special tests you have had:**
☐Stress Test ☐ Ultrasound ☐Angiogram ☐Other:_____

Test	Date (DD/MM/YYYY)	Hospital

22 **Transfusion History:**
Do you have a rare blood type or been told you have antibodies? ☐ No ☐Yes
Do you object to blood and blood product transfusion for any reason? ☐ No ☐Yes
Have you ever received blood or blood products? ☐ No ☐Yes
Did you have any problems? ☐ No ☐Yes

Mini-Cog Score (if available

☐Not available
For patients greater than 65 years of age, Flag at risk for delirium if

☐Greater than 80 years of age

☐Benzodiazepines and/or alcohol greater than 3x/week

☐Glasses and/or hearing aides

☐Mini mental status exam less than 24 or previous delirium

☐Assistance with any activities of daily living
Delirium Risk flags:
_____ /5

If 2 or more flags are present, implement facility protocol.
☐N/A patient less than 65 years of age

23 **Do you smoke?** ☐ No ☐Yes Do you vaporize? ☐ No ☐Yes When did you quit? _____
How many per day? _____ Number of years smoked / vaporized? _____

24 **Do you drink beer / wine / liquor?** ☐ No ☐Yes How much? _____ How Often?_____
Do you use recreation drugs? ☐ No ☐Yes Type? _____ How Often?_____

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25	**Do you have:** ☐Capped or lose teeth ☐Dentures/removable bridge work ☐Upper ☐Lower ☐Contact lenses ☐Hearing aid ☐Left ☐Right ☐Eyeglasses ☐Body piercings: ☐Prosthesis, specify:	***Hospital Use only*** ***Interview Information***
26	**Nutrition Status:** ☐Regular Diet Special diet? ☐ No ☐Yes Type of Diet_____ Describe eating pattern _____ Difficulty eating or swallowing? ☐ No ☐Yes Weight Pattern: ☐Stable ☐Gain ☐Loss- Amount_____ Time period_____ ☐Nausea ☐Vomiting ☐Choking ☐Indigestion ☐Reflux ☐Anorexia	☐Consults Initiated
27	**Elimination Status** ☐Regular ☐ Ostomy ☐ No Concerns Urinary Pattern ☐ Urgency ☐ Frequecy ☐ Incontinent ☐ Get up during the night Describe Urinary Pattern ;_____ Bowel Pattern ☐Diarrhea ☐ Constipation ☐ Incontinent Describe Bowel Pattern ;_____ Other?_____ ☐ No ☐Yes Describe:_____	☐If one or more of The risk for Falls Questions (30b,c or d) is checked yes, complete the Falls Risk Assessment & Interventions for Ambulatory Care/ SDS
28	**Functional Status:** ☐No Concerns Any Changes in activities of daily living? ☐ No ☐Yes Explain:_____	
29	**For Day Surgery Patients:** Fall within 6 months Do you require assistance with toileting, bathing, dressing, walking, and feeding? ☐ No ☐Yes Explain:_____ Do you use any of these: ☐Crutches ☐Cane ☐Walker ☐Wheelchair ☐Scooter ☐Bathroom assists ☐Mechanical Lifts Any changes in sleep pattern? ☐ No ☐Yes Explain:_____ Do you have any pain? ☐ No ☐Yes Explain:_____	
30	**What are your living arrangements?** ☐No Concerns Live: ☐Alone ☐ Spouse/Partner ☐ Children ☐ Pets ☐ Other:_____ Residence: ☐ Apartment ☐ House ☐ Group Home ☐ Personal Care Home ☐ Supportive housing ☐ Assisted Living **Must use stairs** ☐ No ☐Yes Number_____ Is there a railing? ☐ No ☐Yes	
31	**Are you using any community services right now?** ☐ No Services ☐Home Care ☐Physiotherapy ☐Occupational Therapy ☐ Dietitian ☐Day Hospital ☐Lifeline ☐Handi -Transit ☐Other:_____ Treaty Number:_____ Social Assistance: Case Worker Name _____ Contact No._____Case no._____	
32	**Who completed this form?** ☐ Patient ☐Other: Name/Relationship: _____ Date: completed_____	Completed By;_____ Date: (DD/MM/YYYY)

Thank you for taking the time to complete this questionnaire.

Patient Questionnaire is valid for 6 months, provided there has been significant change in the patient's condition.