PRE-OPERATIVE SURGICAL QUESTIONNAIRE

Patient Health History-Patient to Complete

PATIENT INFORMATION		
Name:		Date of Birth:
Preferred name:		Home phone:
Your Height:	Your Weight:	Cell phone:
Surgeon:	Family Doctor:	Family Doctor phone:

Questionnaire completed by?	Patient ☐ Y or ☐ N
Name of person completing Questionnaire:	
Relationship:	**Date completed:**

Have you had previous operations? (Including childbirth. If YES, list below.)

Operations	Anaesthetic Problems

Has there been any change in your general health in the past year? ☐ YES ☐ NO

	Have you or any blood relatives in your family ever had a bad reaction to anaesthetic? If yes, explain:	☐ Yes ☐ No ☐ Unknown
	Is there a family history of **Malignant Hyperthermia** (high fever) during anaesthetic?	☐ Yes ☐ No ☐ Unknown
	Have you ever been told of difficulty with placement of breathing tube during anaesthetic?	☐ Yes ☐ No ☐ Unknown
	Do you have pain / stiffness in your neck /jaw (TMJ)?	☐ Yes ☐ No ☐ Unknown
	Do you Have pain / stiffness in your lower back?	☐ Yes ☐ No ☐ Unknown
	Do you have any loose teeth, capped teeth, braces, retainers, or dentures? (please circle appropriate response)	☐ Yes ☐ No ☐ Unknown
	Do you have any difficulty opening your mouth fully?	☐ Yes ☐ No ☐ Unknown
	Have you had confusion after surgery?	☐ Yes ☐ No ☐ Unknown

Is there any possibility of pregnancy? ☐ YES ☐ NO

ALLERGIES:

Do you have allergies and / or intolerances, adverse reactions? (i.e. Medication, latex, tape, dust/ pollen, food, etc.) ☐ Yes ☐ No ☐ Unknown

Allergic to:	Reaction	Allergic To:	Reaction

SURGICAL CENTRE

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	Medication Name	Dose	Medication Name	Dose

***Please bring all your medications on the day of surgery and attach pharmacy list.

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS? (select all that apply)

Heart Health

☐ Heart attack ☐ Heart Murmur ☐ Angina / Chest Pain ☐ Blockages
☐ Stent/ Angioplasty ☐ Valve Problems ☐ Irregular Heartbeat ☐ Peripheral Vascular Disease
☐ Heart Failure ☐ Heart Failure ☐ Pacemaker or implantable defibrillator
☐ Low Heartbeat ☐ Other: _____

Do you have high blood pressure?	☐ Yes ☐ No ☐ Unknown
Have you had **any recent heart tests in the last 2 years?** (Not ECG) i.e. Stress test, holter monitor, echocardiogram	☐ Yes ☐ No ☐ Unknown
Can you do the following at a normal pace without stopping? Walk 1 block Climb one flight of stairs	 ☐ Yes ☐ No ☐ Yes ☐ No
Do you feel **short of breath when lying flat?**	☐ Yes ☐ No ☐ Unknown
Have you ever had blackouts or fainting spells?	☐ Yes ☐ No ☐ Unknown
Have you ever been told you have an aneurysm?	☐ Yes ☐ No ☐ Unknown
Have you seen a Cardiologist in the past 2 years? Cardiologist's Name: Phone:	☐ Yes ☐ No

Respiratory Health

☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD ☐ Emphysema
☐ Tuberculosis ☐ Tracheostomy ☐ Chronic bronchitis
☐ Pneumonia in the last 3 months ☐ Other: _____

Do you use oxygen at home to help you breathe?	☐ Yes ☐ No ☐ Unknown
Have you seen a respirologist in the past 2 years? Respirologist's Name: _____ Phone: _____	☐ Yes ☐ No ☐ Unknown
Do you have sleep apnea? (diagnosed by a sleep study) If yes, is it: ☐ Mild ☐ Moderate ☐ Severe	☐ Yes ☐ No ☐ Unknown
Was a CPAP machine recommended for you?	☐ Yes ☐ No ☐ Unknown

Endocrine and Metabolic Health

Do you have diabetes?	☐ Yes ☐ No ☐ Unknown
If you have diabetes, how do you manage it?	☐ Insulin ☐ Diabetic Pills ☐ Diet only
Do you have thyroid problems?	☐ Yes ☐ No ☐ Unknown
Other:	

Blood

☐ Diagnosed blood disorder. ☐ Type: _____ ☐ Sickle Cell Anemia
☐ Anemia (low blood count) ☐ Blood clot (in lungs, legs, or elsewhere) ☐ Abnormal Bleeding
☐ HIV / AIDS ☐ Others

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Neurological, Autoimmune

☐ Disease that affects your muscles/ nerves (i.e. Multiple Sclerosis, Parkinson's, ALS)

☐ **Stroke or stroke-like symptoms** ☐ **Brain Aneurysm** ☐ Neuropathy

☐ Seizure Disorder (i.e. epilepsy) ☐ Dementia ☐ Migraines

☐ Fainting spells, vertigo in the past 2 years ☐ Alzheimer's Disease ☐ Other: _____

Have you ever been diagnosed with?

☐ Osteoarthritis ☐ Ankylosing spondylitis ☐ Rheumatoid arthritis

Have you seen a neurologist and / or rheumatologist for any of the above in the past 2 years? Specialist's name: _____ Phone: _____	☐ Yes ☐ No

Stomach and Intestinal Health

☐ Heartburn / Reflux ☐ Hiatus Hernia (Stomach) ☐ Liver Disease (i.e. hepatitis, Jaundice)

☐ Other ☐ Cirrhosis

Do you have difficulty eating or swallowing?	☐ Yes ☐ No

Kidney and Bladder Health

Do you have Kidney disease?	☐ Yes ☐ No ☐ Unknown
Are you on dialysis? If yes, [lease select all that apply: Hemodialysis Peritoneal dialysis	☐ Yes ☐ No ☐ Unknown
Have you seen a nephrologist in the past 2 years? Nephrologist's name: _____ Phone: _____	☐ Yes ☐ No

Other

Do you have a history of Mental Health issues? If yes, please state:	☐ Yes ☐ No
Do you use any ambulatory aids? If yes, please select all that apply: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Crutches	☐ Yes ☐ No
Have you ever had cancer? If yes, please select all the treatments that apply: ☐ Radiation ☐ Chemotherapy ☐ Other	☐ Yes ☐ No ☐ Unknown
Are you taking pain killers regularly?	☐ Yes ☐ No
Do you smoke any of the following products? ☐ CBD ☐ THC ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Marijuana ☐ Number per day? _____ Number of years:_____ Quit date: _____	
Do you drink alcohol? If yes, how many drinks per week?	☐ Yes ☐ No
Do you take recreational drugs? (i.e. cocaine, heroin, marijuana)	☐ Yes ☐ No
Are there any additional health issues / concerns we should be aware of before your surgery?	

Patient health history questionnaire completed by:

Print name	Signature	Relationship to patient	Date (YYYY/MM/DD)