St. Joseph's Healthcare Hamilton

Pre-Operative Patient History Questionnaire

Date (yyyy/mm/dd):_____ / _____ / _____

Patient's Last Name: _____ **First Name:** _____
Age:_____

Surgery:_____

Name of person completing this form if not the patient: _____

Relationship to patient: _____

GENERAL Information:		
Are you allergic to latex? If yes describe reaction: _____ Have you been tested for latex allergy?	☐ Yes ☐ Yes	☐ No ☐ No
Do you have any allergies to any medication? name: _____ reaction: _____ name: _____ reaction: _____ name: _____ reaction: _____ name: _____ reaction: _____		☐ No
Do you have any allergies to food or other allergies? If Yes, list:		☐ No
Have you ever had anesthesia? ☐ General anesthetic ☐ Spinal or Epidural ☐ Nerve block ☐ Sedation (eg. Colonoscopy)		☐ No
Have you had any problems with anesthesia? ☐ Malignant Hyperthermia ☐ Nausea/vomiting ☐ Pseudocholinesterase deficiency ☐ Difficulty with insertion of the anesthesia breathing tube ('difficult intubation') ☐ Other If Yes: Describe: _____		☐ No
Do you have a blood relative who has had problems with anesthesia? ☐ Malignant Hyperthermia (high fever) ☐ Pseudocholinesterase deficiency ☐ Other		☐ No
Do you have any loose teeth? If yes, which teeth _____ Do you have dentures? ☐ partial upper ☐ full upper ☐ partial lower ☐ full lower Do you have: ☐ veneers ☐ caps ☐ crowns ☐ bridges If yes, which teeth _____		☐ No ☐ No ☐ No
Do you get motion sickness?	☐ Yes	☐ No
Do you smoke or have you ever smoked? If Yes: # of cigarettes a day: _____ # of years smoked: _____ Year stopped: _____		☐ No
Do you use recreational drugs, street drugs or marijuana/cannabis? If Yes: Type: _____ Amount: _____ How often: _____ Type: _____ Amount: _____ How often: _____		☐ No
Do you drink alcohol such as beer, wine and/or liquor? If Yes: # of drinks a week: _____	☐ Yes	☐ No

Have you taken cortisone, prednisone or other steroids in the last 3 months?	☐ Yes	☐ No
Have you ever been treated for cancer? If Yes: Type: _____ Year: _____ Have you received *bleomycin* as chemotherapy?	 ☐ Yes	☐ No ☐ No
Could you be pregnant? Date of Last menstrual period _____	☐ Yes	☐ No
Respiratory		
Have you ever been diagnosed with: ☐ asthma ☐ tuberculosis ☐ emphysema ☐ COPD ☐ other breathing or lung problems _____		☐ No
Do you have a Respirologist? If Yes: Name: _____ Last Visit: _____		☐ No
Do you use oxygen at home? If Yes, how much? _____		☐ No
Do you have sleep apnea? If Yes do you: ☐ use CPAP ☐ use BiPAP ☐ don't use CPAP		☐ No
Do you snore loudly enough to be heard through closed doors? Do you often feel tired, sleepy or fatigued during the day? Has anyone observed you stop breathing or choking/gasping during your sleep?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
Do you have a cough with sputum?	☐ Yes	☐ No
Do you have any problems with your breathing? Describe: _____	☐ Yes	☐ No
Have you had a cold, flu or chest infection in the last month?	☐ Yes	☐ No
Cardiovascular		
Have you ever had: ☐ high blood pressure ☐ heart attack ☐ heart murmur ☐ angina ☐ heart failure ☐ irregular heart beat ☐ heart valve problem ☐ other heart problems _____		☐ No
Do you have a Cardiologist? If Yes: Name: _____ Last visit: _____		☐ No
Do you have a: ☐ pacemaker ☐ defibrillator (ICD) ☐ stents ☐ artificial heart valve		☐ No
Have you needed: ☐ heart surgery ☐ carotid surgery ☐ surgery on major arteries or veins		☐ No
Have you had a: ☐ stress test ☐ angiogram ☐ echocardiogram (heart ultrasound)		☐ No
Do you need to stop after walking 2 blocks or less?	☐ Yes	☐ No
Do you need to raise the head of your bed or use more than 1 pillow to sleep?	☐ Yes	☐ No
Do you have problems with circulation in the legs (e.g., peripheral vascular disease)?	☐ Yes	☐ No
Gastrointestinal		
Have you ever had liver problems such as hepatitis or cirrhosis?	☐ Yes	☐ No
Do you have frequent heartburn (GERD), ulcer(s) or a hiatus hernia?	☐ Yes	☐ No
Renal		
Have you ever had kidney disease? Describe: _____	☐ Yes	☐ No
Are you a dialysis patient? ☐ peritoneal ☐ hemodialysis		☐ No
Endocrine		
Do you have diabetes? ☐ Type 1 ☐ Type 2 ☐ Gestational How is your diabetes managed? ☐ diet ☐ oral medication ☐ insulin		☐ No
Do you have thyroid disease? If Yes: ☐ hyperthyroidism ☐ hypothyroidism		☐ No

Neurological/Musculoskeletal		
Have you ever had: ☐ Stroke (CVA) ☐ Mini-Stroke (TIA) ☐ Seizures If Yes: When was your last episode? _____		☐ No
Do you have: ☐ Multiple Sclerosis ☐ Parkinsons ☐ Alzheimers ☐ memory problems ☐ Other neurologic or muscle disorders _____		☐ No
Do you get: ☐ numbness ☐ tingling or ☐ weakness of your arms (☐L, ☐R) or legs (☐L, ☐R)?		☐ No
Do you have arthritis? If Yes: ☐ osteoarthritis ☐ rheumatoid arthritis ☐ Other: _____		☐ No
Hematological		
Have you ever been diagnosed with: ☐ bleeding disorder ☐ Anemia ☐ Sickle cell disease ☐ low blood iron ☐Thalassemia ☐ low platelets ☐ other_____		☐ No
Have you ever had a blood clot in your ☐ legs or ☐ lungs? If yes, when? _____		☐ No
Have you taken any blood thinner medication in the last month? If Yes: Name: _____		☐ No
Have you recently stopped taking a blood thinner? If Yes: When did you stop: _____		☐ No
Do you bruise easily, get nosebleeds, or bleed excessively after brushing teeth?	☐ Yes	☐ No
Skin		
Do you have problems with your skin such as any open area(s) or reddened areas? If Yes: Describe: _____	☐ Yes	☐ No
Mental Health		
Have you ever been treated for: ☐ anxiety ☐ depression ☐ bipolar disease ☐ psychosis ☐ obsessive compulsive disorder ☐ PTSD ☐ schizophrenia ☐ personality disorder ☐ other mental health problem or addiction: _____		☐ No
Are you currently being treated for any of the above mental health illnesses or addictions? Describe: _____	☐ Yes	☐ No
Surgical History Have you had any previous surgery?		☐ No

Surgery	**Year**		

Do you have any other medical problems or specific questions or concerns to discuss with the anesthesiologist?	☐ Yes	☐ No
Vision Do you have normal vision without glasses or lenses? If No: ☐ wear glasses/lenses all the time ☐ wear glasses/lenses just for reading	☐ Yes	

Hearing Do you have normal hearing without the use of a hearing aid(s)? If No: ☐ left hearing aid ☐ right hearing aid ☐ right and left hearing aids	☐ Yes	
Do you have difficulty with any of the following activities? If Yes: ☐ bathing yourself ☐ dressing yourself ☐ feeding yourself ☐ grooming yourself		☐ No
Do you have any weakness in your arms/hands? If Yes: ☐ right ☐ left ☐ both		☐ No
Do you have any weakness in your legs? If Yes: ☐ right ☐ left ☐ both		☐ No
Do you use any assistive devices? If Yes: Check all that apply: ☐ cane ☐ walker ☐ wheelchair ☐ crutches ☐ bed lift ☐ commode ☐ Other _____		☐ No

Living Arrangements		
Who do you live with? ☐ alone ☐ spouse/significant other/partner ☐ child/children ☐ friend ☐ Other family member: Who? _____		
Support services you use: ☐ none ☐ CCAC ☐ Homecare ☐ therapist ☐ Other:_____		
Where do you live? ☐ house/apartment/condo ☐ homeless ☐ group home ☐ assisted living ☐ retirement home ☐ nursing home		
Do you have a responsible adult to stay with you at home on the night of your surgery if you are going home the same day as your surgery? Where do you expect to go after being discharged home from surgery? _____ Write name, phone number here if different than home address?	☐ Yes	☐ No
Do you have any religious or cultural practices that you would like us to know about? If Yes: Describe:	☐ Yes	☐ No
Is there anything else we need to know about you to assist you during your hospital stay? If Yes: Describe:	☐ Yes	☐ No

Medications and Supplements

<u>Bring</u> ALL your current medications in their original containers AND an up-to-date list of medications from your pharmacist. Include prescription and non-prescription medication you take including inhalers, creams patches, drops, vitamins and herbal supplements. If you have your list of your medications from the pharmacist you do not need to write these medications here. You can attach to this form.

Name	Dose	How often	Reason