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PATIENT QUESTIONNAIRE (Adult)
Pre-Surgical Health History

COMPLETE ALL 4 PAGES: WRITE N/A IF QUESTION DOES NOT APPLY.

Date: _____ **Legal Name:** _____

Date of Birth: _____ **Female** ❑ **Male** ❑ **Personal Health Number:** _____

Address: _____

E-mail: _____ **Home Phone:** _____ **Mobile Phone:** _____

Do you have cultural or religious beliefs you would like us to know about?
If yes, Explain: _____ **Primary Language:** _____

Form completed by: ☐ **Patient** ☐ **Family member, Friend, Other Name:** _____

HEIGHT:	**WEIGHT:**

Do you have any allergies to medicine, food or environment (including latex, rubber gloves)?
Yes ❑ No ❑ **If yes, list below.**

Allergy / Sensitivity	**How you react:**

Have you had surgery in the past? Yes ❑ No ❑ **If yes, write below.**

Date	**What surgery did you have?**	**What hospital / city?**

Have you or a blood relative had problems with local freezing or general anesthetic? ❑ Yes ❑ No
If yes, explain: _____

Screening for Sleep Apnea:		
A. Have you been diagnosed with sleep apnea (stop breathing while you are asleep)?	Yes ❑	No ❑
B. Do you have a CPAP machine, or dental device to help you breathe while sleeping?	Yes ❑	No ❑
If you answered NO to "A" and "B", complete questions 1 to 4:		
1. Do you snore loudly (louder than talking or can be heard through closed doors)?	Yes ❑	No ❑
2. Do you often feel tired, fatigued, or sleepy during daytime?	Yes ❑	No ❑
3. Has anyone observed you stop breathing during your sleep?	Yes ❑	No ❑
4. Do you have or are you being treated for high blood pressure?	Yes ❑	No ❑

Have you or do you smoke tobacco / cigarettes?	Yes ❑	No ❑
If yes, Number/Day_____ Number of years_____ Date last cigarette _____		
Ongoing breathing or lung problems?	Yes ❑	No ❑
If yes, what type: _____		

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Do you have or have you had any of the following:					
Ongoing problems swallowing, chewing or opening your mouth	❑ Yes	❑ No	Asthma	❑ Yes	❑ No
			Chronic obstructive lung disease	❑ Yes	❑ No
Nausea or vomiting after surgery	❑ Yes	❑ No	Hiatus hernia	❑ Yes	❑ No
Confusion after surgery	❑ Yes	❑ No	Ongoing heart burn or acid reflux	❑ Yes	❑ No
Seizures. Date of last:	❑ Yes	❑ No	Stomach ulcers	❑ Yes	❑ No
Anxiety or panic attacks	❑ Yes	❑ No			
Spine injury	❑ Yes	❑ No	Cirrhosis	❑ Yes	❑ No
Back or neck pain or deformity that limits movement	❑ Yes	❑ No	Kidney disease. Type: _____ Dialysis: ❑ Hemo ❑ Peritoneal	❑ Yes	❑ No
Parkinsons	❑ Yes	❑ No	Women- Could you be pregnant? If yes, how many weeks? _____	❑ Yes	❑ No
Multiple Sclerosis	❑ Yes	❑ No	Blood disease _____	❑ Yes	❑ No
High blood pressure	❑ Yes	❑ No	Bleeding Problems _____	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No	Infection: ❑ HIV ❑ TB ❑ Hepatitis type: _____	❑ Yes	❑ No
Angina, chest pain or pressure	❑ Yes	❑ No	Thyroid problem: Type: _____	❑ Yes	❑ No

Heart failure	❑ Yes	❑ No	Diabetes - Controlled by: ❑ Insulin ❑ Pills ❑ Diet	❑ Yes	❑ No
Heart valve problem	❑ Yes	❑ No	Lupus	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	Rheumatoid arthritis	❑ Yes	❑ No
Heart beat: ❑ too fast ❑ irregular	❑ Yes	❑ No	Osteoarthritis	❑ Yes	❑ No
Pacemaker or heart defibrillator	❑ Yes	❑ No	Muscle disease: Type: _____	❑ Yes	❑ No
Recent or ongoing dizzy or fainting spells	❑ Yes	❑ No	Cancer: Type _____ **❑ chemo ❑ radiation Last dose: _____**	❑ Yes	❑ No
Blood clot in lung or leg	❑ Yes	❑ No	**Other:**		
Stroke or TIA. Date: _____	❑ Yes	❑ No			
Are you able to climb two flights of stairs? If no, why? ❑ short of breath ❑ too tired ❑ chest pain	❑ Yes	❑ No			

List the name of any specialist you've seen.	Date of last visit		List the name of any specialist you've seen.	Date of last visit	
❑ Heart /cardiac Dr.			❑ Blood/haematologist Dr.		
❑ Lung/respirologist Dr.			❑ Neurologist Dr.		
☑ **below to any test you've had.**	**Where**	**When**	☑ **below to any test you've had.**	**Where**	**When**
❑ Exercise test or treadmill			❑ Heart ultrasound or echo test		
❑ Holter monitor for 24 hours			❑ Heart scan MIBI		
❑ Heart cath or angiogram			❑ Pulmonary lung function test		

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How sure are you that you can manage at home after surgery? Circle the number.

0 1 2 3 4 5 6 7 8 9 10

Not sure **Very sure**

On average how many alcoholic drinks do you have per week? ☐ None ☐ 1 to 7 ☐ 8 or more

1 drink is: 5 ounces of wine, 1.5 ounces of hard liquor, 12 ounces of beer.

Do you take any over the counter or prescribed medicines? Any vitamins? Any herbal? Any drugs such as marijuana, cocaine, heroin? Write below or attach list.

Medication	Dose	How often?	Medication	Dose	How often?

Pain	**Yes**	**No**	**Not Sure**
In the past 2 weeks:			
Have you had pain in any part of your body most days?			
Have you taken or used any medicine for pain?			
Have you done other things or used other products to help reduce your pain? (such as heat or cold, massage, deep breathing, ointments or herbal remedies)			

Medications	**Yes**	**No**	**Not Sure**
In the past 2 weeks, have you taken or used any medicines either regularly or when needed? (including medicines ordered by your doctor and ones bought on your own from a pharmacy, health food or herbal medicine store)			
Do you have any of the following concerns with your medications, such as: ☐ Forgetting to take them ☐ Knowing how, when, or why you take them ☐ Getting to the pharmacy ☐ Paying for your medications			
In the past 28 days, have you or your doctor changed the medicines you are taking? (such as the amount of medicine you take, how often you take the medicine, or if you have stopped or started taking a medicine)			

Eating and drinking (Nutrition/Hydration)	**Yes**	**No**	**Not Sure**
Have you lost weight recently without trying?			
If 'Yes', how much weight have you lost? ☐ Unsure ☐ 1 to 5 kilograms (2.2 to 11 pounds) ☐ 6 to10 kilograms (13 to 22 pounds) ☐ 11 to 15 kilograms (24 to 33 pounds) ☐ More than 15 kilograms (33 pounds)			
Have you been eating poorly because of a decreased appetite?			
Have you had any trouble swallowing food or drinks?			
Have you had any trouble chewing food?			
Have you been repeatedly treated with antibiotics for lung problems?			
Have you needed help to make meals?			
Have you needed help to feed yourself?			

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Going to the toilet (Bowel & Bladder)	**Yes**	**No**	**Not Sure**
In the past 2 weeks, have you had any problems urinating (going 'pee')? (this could include pain, going more often, trouble going, feeling the need to go right away, or leaking)			
In the past 2 weeks, have you had any problems with your bowel movements (going 'poo')? (this could include being constipated (finding it really hard to go) or having diarrhea (watery poo)			
Do you need help going to the toilet?			

Moving around - How mobile are you?(Mobility)	**Yes**	**No**	**Not Sure**
Do you usually use a walking aid such as a cane or walker?			
In the past 2 weeks, have you had any trouble doing any of the following: Getting out of bed or out of a chair?			
Getting dressed, bathing, or showering?			
Walking?			
Climbing stairs?			
If 'Yes' to any of these, could you only do it with someone's help?			
In the last 12 months have you fallen, tripped, slipped, or almost fallen?			

Thinking, mood, and memory (Cognition)	**Yes**	**No**	**Not Sure**
In the past 2 weeks: Have you felt confused or uncertain about what is going on around you?			
Have you found it harder to think, focus on things, or remember to do certain things?			
Have you felt sad, down, or not interested in life?			
Have you had trouble getting interested or feeling pleasure in doing things you usually enjoy?			
If you said 'Yes' to any of these questions, has this made it hard for you to do activities such as getting dressed, making meals, going grocery shopping or visiting with family or friends?			

For Staff Only ☐ **Unable to complete**
Reason: Initials:

Preop day of Admit: BP_____ P_____ R _____ SPO2 _____ Glucometer (if diabetic) _____ Height _____ Weight _____

Reviewed & Initial	☐ Note ☐ Care plan	Date:	Time:
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