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PATIENT QUESTIONNAIRE (Adult)

Pre-Surgical Health History



Form ID: ORPO104973D

Rev: Mar 04/16

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

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

Heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes - Controlled by: <input type="checkbox"/> Insulin <input type="checkbox"/> Pills <input type="checkbox"/> Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart valve problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart beat: <input type="checkbox"/> too fast <input type="checkbox"/> irregular	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pacemaker or heart defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle disease: Type: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Recent or ongoing dizzy or fainting spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer: Type _____ <input type="checkbox"/> chemo <input type="checkbox"/> radiation Last dose: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Blood clot in lung or leg	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:			
Stroke or TIA. Date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Are you able to climb two flights of stairs? If no, why? <input type="checkbox"/> short of breath <input type="checkbox"/> too tired <input type="checkbox"/> chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> 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		
<input type="checkbox"/> Heart /cardiac Dr.		<input type="checkbox"/> Blood/haematologist Dr.			
<input type="checkbox"/> Lung/respirologist Dr.		<input type="checkbox"/> Neurologist Dr.			
<input checked="" type="checkbox"/> below to any test you've had.	Where	When	<input checked="" type="checkbox"/> below to any test you've had.	Where	When
<input type="checkbox"/> Exercise test or treadmill			<input type="checkbox"/> Heart ultrasound or echo test		
<input type="checkbox"/> Holter monitor for 24 hours			<input type="checkbox"/> Heart scan MIBI		
<input type="checkbox"/> Heart cath or angiogram			<input type="checkbox"/> 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 to 10 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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