



PRE-OP HEALTH HISTORY PATIENT QUESTIONNAIRE

Dear Patient: Please complete this health history questionnaire to the best of your ability and give it to your surgeon's office team. If you are not sure of any answer, check "not sure". You can add details in the "Comments" box.

| | | | |
|-------------------------|-------------------|---|--|
| Name | | ☎ Home | Cell |
| Email address: | | Preferred language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (specify): | |
| Height: | feet/inches or cm | Weight: | lbs or kgs |
| Family Physician | | | For office use only BMI |
| | | ☎ | Date of birth (yyyy/mm/dd) <input type="checkbox"/> Male <input type="checkbox"/> Female |

HEART

| Do you have: | Yes | No | Not sure | Comments | |
|---|-----|----|----------|--|---|
| 1. Any heart problem? (e.g., heart attack, murmur, angina, blockages, angioplasty, stent, valve problems, irregular heartbeat, heart surgery, heart failure). | | | | <i>Specify:</i> | * |
| 2. High blood pressure? | | | | <input type="checkbox"/> not well controlled <input type="checkbox"/> well controlled | * |
| 3. Chest pain or breathlessness after climbing 2 flights of stairs? | | | | | * |
| 4. A pacemaker or an implantable defibrillator? | | | | | * |
| 5. Do you take Aspirin (ASA) regularly? | | | | <i>Why?</i> | |
| 6. A prescription for blood thinners? (e.g., warfarin, coumadin, plavix, dabigatran, rivaroxaban) | | | | | * |
| 7. An artificial heart valve? | | | | | * |
| 8. Any other artificial implants that require you to take antibiotics before surgery, or going to the dentist? e.g., knee, hip, other). | | | | <i>Specify:</i> | |
| 9. Any other heart issues? | | | | <i>Specify:</i> | |

BREATHING

| Do you have: | Yes | No | Not sure | Comments | |
|--|-----|----|----------|--|---|
| 10. Emphysema, chronic obstructive pulmonary disease (COPD) or chronic bronchitis? | | | | | * |
| 11. Asthma? | | | | <input type="checkbox"/> not well controlled <input type="checkbox"/> well controlled | * |
| 12. Sleep apnea? (diagnosed by a physician) | | | | | * |
| 13. A problem lying flat for at least 30 minutes because of difficulty breathing? | | | | | * |

BREATHING

| Do you use: | Yes | No | Not sure | Comments | |
|---|------------|-----------|-----------------|-------------------|---|
| 14. A breathing machine to help you sleep? | | | | | * |
| 15. Inhalers (puffers)? | | | | <i>How often?</i> | |
| 16. Oxygen at home to help you breathe? | | | | | * |
| 17. Do you smoke tobacco of any kind? (e.g., cigarettes, cigars, pipes). | | | | <i>Specify:</i> | |
| | | | | number /day: | |
| | | | | number of years: | |
| 18. Have you had shortness of breath for which you have been admitted to hospital within the last 2 months? | | | | | * |
| 19. Have you had pneumonia in the past 2 months? | | | | | * |
| 20. Do you have any other breathing issues? | | | | | |

BLOOD PROBLEMS

| Have you ever been treated for: | Yes | No | Not sure | Comments | |
|---|------------|-----------|-----------------|-----------------|---|
| 21. Sickle cell anemia? | | | | | * |
| 22. Anemia (low blood count)? | | | | | |
| 23. A bleeding disease or problem? | | | | <i>Specify:</i> | * |
| 24. Blood clots (in your lungs, legs or other)? | | | | <i>Specify:</i> | * |
| 25. Have you had a blood transfusion within the last 3 months? | | | | | |
| 26. Do you have any personal or religious reasons for refusing to have any blood products given to you? | | | | | * |

NEUROLOGICAL

| Do you have/have you had: | Yes | No | Not sure | Comments | |
|--|------------|-----------|-----------------|-----------------|---|
| 27. Memory problems or confusion? | | | | | * |
| 28. A history of extreme confusion after an operation? | | | | | * |
| 29. A disease that affects your muscles and nerves? | | | | | * |
| 30. A stroke or stroke- like symptoms in the past? | | | | | * |
| 31. Any aneurysm? | | | | | * |
| 32. Epilepsy or convulsions? | | | | | * |
| 33. Dizziness? | | | | | |
| 34. Fainting spells? | | | | | * |

OTHER IMPORTANT MEDICAL INFORMATION

| | Yes | No | Not sure | Comments | |
|---|------------|-----------|-----------------|-----------------|---|
| 35. Do you have family (blood relatives) who have had serious problems following an anesthetic? | | | | | * |
| 36. Have you had serious problems following an anesthetic (e.g., malignant hyperthermia)? | | | | <i>Specify:</i> | * |
| 37. Do you have trouble opening your mouth, jaw or moving your neck? | | | | | * |

| OTHER IMPORTANT MEDICAL INFORMATION | | | | |
|--|------------|-----------|-----------------|---|
| | Yes | No | Not sure | Comments |
| 38. Do you have a chronic pain disorder? | | | | * |
| 39. Are you pregnant? | | | | * |
| 40. Is there a possibility that you could be pregnant? | | | | |
| 41. Are you diabetic? | | | | <input type="checkbox"/> on insulin |
| | | | | <input type="checkbox"/> on diabetic pills |
| | | | | <input type="checkbox"/> diet controlled |
| 42. Are you on dialysis? | | | | * |
| 43. Do you have kidney disease? | | | | * |
| 44. Do you have thyroid disease? | | | | <input type="checkbox"/> not well controlled |
| | | | | <input type="checkbox"/> well controlled |
| 45. Do you have a urinary tract infection? | | | | |
| 46. Have you had an infection requiring isolation in the hospital? | | | | |
| 47. Do you currently have a cold, chest infection or fever? | | | | * |
| 48. Are you HIV positive? | | | | <input type="checkbox"/> not on treatment |
| | | | | <input type="checkbox"/> on treatment |
| 49. Do you have liver disease? | | | | * |
| 50. Have you had an organ transplant? | | | | * |
| 51. Do you have stomach ulcers, heartburn or a hiatus hernia? | | | | |
| 52. Do you have arthritis? | | | | <input type="checkbox"/> rheumatoid arthritis |
| | | | | <input type="checkbox"/> osteoarthritis |
| 53. Do you have an autoimmune disease? (e.g., lupus) | | | | * |
| 54. Have you had radiation treatment? | | | | <input type="checkbox"/> to the head or neck |
| | | | | <input type="checkbox"/> abdomen |
| | | | | <input type="checkbox"/> other: |
| 55. Do you drink more than 14 alcoholic beverages per week? | | | | <i>Total per week:</i> * |
| 56. Do you use any street drugs? | | | | * |
| 57. Do you have a hearing impairment or wear a hearing aid? | | | | |
| ALLERGIES | | | | |
| Do you have allergies to: | Yes | No | Not sure | Comments |
| 58. Latex? | | | | |
| 59. Eggs? | | | | |
| 60. Other food? | | | | |
| 61. Medication? | | | | <i>Name?</i> |
| 62. Metal? | | | | |
| 63. Anything else? | | | | |

DISCHARGE PLANNING AND MOBILITY

| | Yes | No | Not sure | Comments |
|--|-----|----|----------|------------------|
| 64. Do you use a wheelchair, walker, cane, scooter or other aid? | | | | |
| 65. Do you have problems with your balance? | | | | |
| 66. Have you had a fall in the last 3 months? | | | | * |
| 67. When discharged, do you have a responsible adult to drive you home following your surgery? | | | | |
| 68. Do you have someone available to stay with you overnight and help care for you? | | | | |
| 69. Do you presently receive services from home care? (CCAC) | | | | |
| 70. Do you live in a retirement home, boarding home or long term care facility, or other? | | | | <i>Specify:</i> |
| 71. Do you live more than 100 km away from The Ottawa Hospital? | | | | |
| 72. Do you have to climb stairs when you are at home? | | | | <i>How many?</i> |

LIST ANY SURGERIES OR MINOR PROCEDURES USING ANESTHETIC YOU HAVE HAD IN THE PAST.

| Procedure | Year | Procedure | Year |
|-----------|------|-----------|------|
| 1. | | 9. | |
| 2. | | 10. | |
| 3. | | 11. | |
| 4. | | 12. | |
| 5. | | 13. | |
| 6. | | 14. | |
| 7. | | 15. | |
| 8. | | 16. | |

LIST ANY OTHER UPCOMING PROCEDURES (other than your surgery) AND WHEN THEY ARE SCHEDULED?

| Procedure | Month/Year | Procedure | Month/Year |
|-----------|------------|-----------|------------|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

INDICATE PHARMACY NAME AND TELEPHONE NUMBER

Your pharmacy name:

Phone number (or location of pharmacy)

LIST ALL OF THE MEDICATIONS THAT YOU TAKE (INCLUDING HERBAL MEDICATION, VITAMINS, AND NON PRESCRIPTION DRUGS). ATTACH LIST IF NECESSARY.

1.

13.

2.

14.

3.

15.

4.

16.

5.

17.

6.

18.

7.

19.

8.

20.

9.

21.

10.

22.

11.

23.

12.

24.

Do you have any other illness, limitations or any other concerns we should know about? Yes No

Specify:

Patient Health History Questionnaire completed by: Patient Family Member Health Care Provider Other (specify):

Print name(s)

Signature

Date (yyyy/mm/dd)

Time

IMPORTANT: Please remember to let your surgeon know if you think you are getting a cold, flu or illness or if you start taking any new medications.**Thank you!**

For OFFICE use ONLY.

Notes:

| | | | |
|--------------|-----------|-------------------|------|
| Printed name | Signature | Date (yyyy/mm/dd) | Time |
|--------------|-----------|-------------------|------|

For Surgeon's Administrative use ONLY.

Scheduled procedure: _____

Scheduled procedure date: Date (yyyy/mm/dd) _____ Campus: Civic General Riverside

Surgeon: _____ Department: _____ Office telephone: _____

Office contact name: _____ Signature: _____ Office fax: _____

Additional comments:

For Pre-Admission Unit (PAU) use ONLY.

Pre-Admission Unit Appointment Type:

- RN Assessment (clinic visit) RN Telephone Telemedicine (RN only) Chart Review
- Anesthesia/RN Assessment (clinic visit) Telemedicine (Anesthesia/RN) Telemedicine (Anesthesia only)
- Other (specify): _____

Patient Questionnaire Reviewed by: Pre-Admission Unit RN Other

Notes:

| | | | |
|-----------------|-----------|-------------------|------|
| Printed name(s) | Signature | Date (yyyy/mm/dd) | Time |
|-----------------|-----------|-------------------|------|