The Ottawa Hospital | L'Hôpital d'Ottawa

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 "Please specify" box.

Name:	☎ Home:	Cell:
Email address:	Preferred language: ❑ English ❑ French ❑ Other (specify):	Date of birth (yyyy/mm/dd):
Height: feet/inches or cm	**Weight:** lbs or kgs	❑ Male ❑ Female
Family Physician:	☎	For office use only **BMI**

HEART

Do you have:		Yes	No	Not sure	Please specify	
1.	Any heart problem? (e.g., heart attack, murmur, angina, blockages, angioplasty, stent, valve problems, irregular heartbeat, heart surgery, heart failure).					*
2.	High blood pressure or take medication for high blood pressure?					
3.	Chest pain or breathlessness after climbing 1 flight of stairs?					*
4.	A pacemaker or an implantable defibrillator?					*
5.	Do you take Aspirin (ASA) regularly?				Why?	
6.	A prescription for blood thinners? (e.g., warfarin, coumadin, plavix, dabigatran, rivaroxaban)					*
7.	An artificial heart valve?					*
8.	Any other heart issues?					

BREATHING

Do you have:		Yes	No	Not sure	Please specify	
9a.	Have you smoked tobacco of any kind in the past? Please indicate which (e.g., cigarettes, cigars, pipes, marijuana).				Number/day: Number of years:	
9b.	Have you quit smoking?				When?	
10.	Emphysema, chronic obstructive pulmonary disease (COPD) or chronic bronchitis?					*
11a.	Asthma?					
11b.	Asthma needing your relief medication more than twice per week or oral steroids in the last 2 months?					*
12.	Do you use inhalers (puffers)?				How often?	
13.	Do you use oxygen at home to help you breathe?					*
14.	A problem lying flat for at least 30 minutes because of difficulty breathing?					*
15.	Have you had shortness of breath for which you have been admitted to hospital within the last 2 months?					*

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BREATHING					
Do you have:	**Yes**	**No**	**Not sure**	**Please specify**	
16. Have you had pneumonia in the past 2 months?					*
17a. Do you have sleep apnea?					
17b. Have you been told to use a machine to help you breathe at night but choose not to use it?					*
18. Do you have any other breathing issues?					
BLOOD PROBLEMS					
Have you ever been treated for:	**Yes**	**No**	**Not sure**	**Please specify**	
19. Sickle cell anemia?					*
20. Anemia (low blood count)?					
21. A bleeding disease or clotting problem?					*
22. Have you had a blood transfusion within the last 3 months?					
23. Do you have any personal or religious reasons for refusing to have any blood products given to you?					*
NEUROLOGICAL					
Do you have or have you had:	**Yes**	**No**	**Not sure**	**Please specify**	
24. Significant memory problems or dementia?					*
25. A history of extreme confusion after an operation?					*
26. A disease that affects your muscles and nerves?					*
27. A stroke or mini-stroke/TIA?					*
28. An aneurysm?					
29. Epilepsy or convulsions?					
More than two months ago:					
In the last two months:					*
OTHER IMPORTANT MEDICAL INFORMATION					
Do you have or have you had:	**Yes**	**No**	**Not sure**	**Please specify**	
30. Fainting spells in the last year?					*
31. If you had a previous admission to hospital?				When?	
				Where?	
				Why?	
32. Have you or your family (blood relatives) had serious problems following an anesthetic other than nausea or vomiting (e.g., malignant hyperthermia)?					*
33. Trouble opening your mouth, jaw or moving your neck up or down?					*

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OTHER IMPORTANT MEDICAL INFORMATION

Do you have or have you had:		Yes	No	Not sure	Please specify			
34.	Do you take narcotics (like codeine, morphine, HYDROmorphONE, percocet, methadone or suboxone) for chronic pain?				Drug	Dose	Frequency	*
35.	Are you pregnant?							*
36.	Is there a possibility that you could be pregnant?							
37.	Are you diabetic?				❑ on insulin			*
					❑ on diabetic pills			
					❑ diet controlled			
38.	Are you on dialysis?							*
39.	Do you have kidney disease?							*
40.	Do you have thyroid disease?				❑ not well controlled			*
					❑ well controlled			
41.	Do you have a urinary tract infection?							
42.	Have you had an infection requiring isolation in the hospital?							
43.	Do you currently have a cold, chest infection or fever?							*
44.	Are you HIV positive?				❑ not on treatment			*
					❑ on treatment			
45.	Do you have liver disease?							*
46.	Have you had an organ transplant (other than cornea)?							*
47.	Do you have stomach ulcers, heartburn or a hiatus hernia?							
48.	Do you have arthritis?				❑ rheumatoid arthritis			*
					❑ osteoarthitis			
49.	Do you have an autoimmune disease? (e.g., lupus)							*
50.	Do you have or have you had cancer?				Where?			
51.	Have you had radiation treatment?				❑ to the head or neck			*
					❑ other:			
52.	Do you have any mental health concerns? (e.g., anxiety, panic attacks, claustrophobia, needle phobia etc.)							
53.	Male patients: On average do you drink more than 3 alcoholic drinks per day, or 21 drinks per week?				Total per week:			*
	Female patients: On average do you drink more than 2 alcoholic drinks per day, or 14 drinks per week?							*
54.	Do you use any street drugs other than marijuana?							*
55.	Do you have a hearing impairment or wear a hearing aid?							

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ALLERGIES

Do you have allergies to:		Yes	No	Not sure	Please specify	
56.	Latex?					
57.	Eggs?					
58.	Other food?					
59.	Medication?				Name:	
60.	Metal?					
61.	Anything else?					

DISCHARGE PLANNING AND MOBILITY

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

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.	

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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: 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.

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FOR PRE-ADMISSION (PAU) USE ONLY

Pre-Admission Unit Appointment Type:

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

Patient Questionnaire Reviewed by:

- ❑ Pre-Admission Unit RN
- ❑ Other

Notes:

Print name:	Signature:	Date (yyyy/mm/dd):	Time: