Interlake–Eastern
Regional Health Authority

Pre-operative Assessment
Patient Questionnaire

Please complete this form to help our Health Care Team meet your medical needs

Date Completed: _____

Hospital Use Only

1. Legal Name: _____ _____ _____
   Surname Middle First
2. How old are you? _____ Gender: ☐ M ☐ F
3. Home #: _____ Cell # _____ Alternate # _____
4. Do you have a Health Care Directive? ☐ Yes ☐No ☐Copy Attached
   Power of Attorney: _____ Phone # _____
5. What Language do you speak/understand? ☐ English ☐French ☐Other _____
   Will you need an interpreter? ☐ Yes ☐ No
6. Contact Person: _____ Relationship: _____
   Phone Number: _____ Alternate #: _____
7. Have you been hospitalized for more than 24 hours or spent more than 24 hours in an Emergency Department in the past 6 months? ☐ Yes ☐ No
   Have you been hospitalized or investigated for the following in the past 6 months?
   ☐ Tuberculosis (TB) ☐ C. difficile ☐MRSA ☐ Other _____
8. Do you have allergies and/or intolerances (i.e. medication, latex, tape, food etc)
   ☐ Yes ☐ No If yes, please list below:

Allergic to:	Reaction:

9. Do you wear a Medic Alert Bracelet? ☐ Yes ☐No
   What does it say? _____
10. List home medications or attach a copy of your medication list ☐ copy attached
    - Prescription medications (birth control pills, cream, eye drops, inhalers, insulins, patches, sleeping pills, etc)
    - Over the counter medications (aspirin, cold/allergy drugs, laxatives, vitamins)
    - Herbs or others (garlic, gingko biloba, St. John's Wort)

Drug Name	Dose (grams or mg)	How often	Reason

If coming to the Preoperative Assessment Clinic, please bring the containers of all prescription and over the counter medications with you.

11. Family Doctor's Name: _____
    Date of last visit (DD/MMM/YYYY) _____ Reason _____
12. List the name of any specialists you've seen:

Specialist	Date of last visit	Specialist	Date of last visit
☐ Heart/Cardiac Dr.		☐ Blood/haematologist Dr.	
☐ Lung/Respirologist Dr.		☐ Neurologist Dr.	

Interview Information

T_____P_____RR_____

☐ Right Arm
BP_____ ☐ Left Arm

O_2 SATS _____

Weight_____Height_____

BMI_____

☐Surveillance Swab sent

☐ Medication Reconciliation completed for Same Day Admission

Interlake-Eastern
Regional Health Authority

Pre-operative Assessment Patient Questionnaire Con't

13. Is it possible that you could be pregnant? ☐ Yes ☐ No Last Menstrual Period_____

14. How tall are you?_____ What is your weight?_____ lbs or kgs

15. Do you have Obstructive Sleep Apnea (OSA)?
- Have you had a sleep study? ☐ Yes ☐ No
- Do you use a CPAP/BiPAP machine? ☐ Yes ☐ No
- Do you snore loudly? (loud enough to be heard through closed doors?) ☐ Yes ☐ No
- Do you think you have abnormal or excessive sleepiness during the day? ☐ Yes ☐ No
- Has anyone noticed that you momentarily stop breathing in your sleep? ☐ Yes ☐ No
- Is your neck measurement greater than 40cm/16 inches? ☐ Yes ☐ No

16. In the past 6 months have you felt short of breath or chest tightness while:
☐ lying flat in bed? ☐ walking two blocks? ☐ doing house work/getting dressed?
☐ doing yardwork/raking leaves/weeding?
Can you climb 1 flight of stairs without stopping to rest? ☐ Yes ☐ No ☐ Unsure

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☐ Known OSA (PAC referral required)
☐ High Clinical Suspicion (PAC referral required)
☐ Low Clinical Suspicion
☐ OSA Identification Assessment Form completed #6866

17. Health History: Place a mark (X) and indicate the year - if you have had any of these: ☐ None

Health Concern	Date	Health Concern	Date
☐ Chest Pain		☐ Bone or joint issues/arthritis	
☐ Angina/Heart Related Chest pain		☐ Chronic Pain; Location: _____	
☐ Heart Attack		☐ Frequent Heart Burn/Acid reflux	
☐ Congestive Heart Failure		☐ Ulcers	
☐ Heart Murmur		☐ Malignant Hyperthermia	
☐ Heart beats fast, skipped beats		☐ Hepatitis/Jaundice/ Liver Disease/Bowel problems (ie Crohn's, Colitis)	
☐ Rheumatic Fever			
☐ High Blood Pressure		☐ Kidney/Bladder problems	
☐ Diabetes		☐ Hemodialysis	
☐ Persistent swelling in legs and/or feet		☐ Peritoneal Dialysis	
☐ Lung problems		☐ Cancer; Location: _____	
☐ Shortness of breath, Cough, wheeze		☐ HIV/AIDS	
☐ Asthma/COPD exacerbation		☐ Anemia/Low Iron	
☐ Inhaler use		☐ Bleeding Disorders	
☐ Transient Ischemic Attack (TIA)/Mini-stroke		☐ Sickle Cell Disease	
☐ Migraines/Headaches		☐ Blood Clots (legs, lungs, Pelvis	
☐ Blackouts/fainting spells in the last year		☐ Family history of blood clots	
☐ Seizures		☐ Thyroid problems	
☐ Recent memory loss		☐ Mental Health Issues	
☐ Disease of Nervous System (ie MS)		☐ Depression	
☐ Dementia		☐ Anxiety/Panic Attacks	
☐ Parkinson's Disease/tremors		☐ Pseudocholinesterase Deficiency	
☐ Implanted Electronic Device (pacemaker, Internal, Internal pain stimulator) Date of last visit:_____		☐ Other	

Have you ever had anesthetic? ☐ Yes ☐ No
Have you ever had a problem with an anesthetic? ☐ Yes ☐ No
Explain:_____
Has anyone in your family ever had a problem with an anesthetic? ☐ Yes ☐ No
Explain:_____

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Pre-operative Assessment Patient Questionnaire Con't

18. List any operations you have had:

Operation	Year	Hospital

19. List any special tests you have had:

Test	Year/Hospital	Test	Year/Hospital
☐ Stress Test		☐ PFT's; Breathing Tests	
☐ Ultrasound		☐ Spirometery	
☐ Echo		☐ Other	
☐ Angiogram			

20. Transfusion History:
Do you have a rare blood type or been told that you have antibodies? ☐ Yes ☐ No
Do you object to blood and blood product transfusion for any reason? ☐ Yes ☐ No
Did you have any problems? ☐ Yes ☐ No

21. Do you Smoke? ☐ Yes ☐ No Do you Vaporize? ☐ Yes ☐ No
How many per day? _____ Number of years smoked/vaporized? _____
When did you quit? _____

22. Do you drink beer/wine/liquor? If ☐ Yes How much? _____ How Often? _____

23. Do you use recreational drugs? If ☐ Yes How much? _____ How Often? _____

24. Functional Status: ☐ No Concerns
Any changes in activities of daily living? ☐ Yes ☐ No
Explain: _____
Falls within 12 months? ☐ Yes ☐ No
Do you require assistance with toileting, bathing, dressing, walking, feeding? ☐ Yes ☐ No
Explain: _____
Do you use any of these? ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair
☐ Scooter ☐ Mechanical Lift ☐ Bathroom Assist
Explain: _____

25. What are your living arrangements? ☐ No concerns
Lives: ☐ Alone ☐ Spouse/Partner ☐ Child(ren) ☐ Pets ☐ Other: _____
Residence: ☐ Apartment ☐ House ☐ Group Home ☐ Personal Care Home
☐ Supportive Housing ☐ Assisted Living
☐ Other Explain: _____
Must use stairs: ☐ Yes ☐ No How Many? _____ Is there a railing? ☐ Yes ☐ No

26. Are you using any community services right now? ☐ No Services
☐ Home Care ☐ Physiotherapy ☐ Occupational Therapy
☐ Dietitian ☐ Day Hospital ☐ Lifeline
☐ Social Assistance Case Worker Name: _____ Phone# _____ Case # ____

Who Completed this form? ☐ Patient ☐ Other
Name/Relationship: _____

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Screened by RN: _____
Date: (DD/MMM/YYYY)/Time _____

Assessed by RN: _____
Date: (DD/MMM/YYYY)/Time _____

Screened by RN: _____

Thank you for taking the time to complete this questionnaire.

Patient Questionnaire is valid for 6 months, provided there has been no significant change in the patient's condition.