Date Completed: (DD/MMM/YYYY) ____________

PHIN: ____________

PreOperative Assessment Patient Questionnaire

Please complete this form to help our Health Care Team meet your medical needs.
Please return this form to your surgeon's clinic. This information is needed at least 3 weeks before you surgery.

Hospital Use Only

Interview Information

T_____ P_____ RR_____

BP_________ ☐ Rt Arm ☐ Left Arm

0_2 SATS ________

Weight ________

Height ________

BMI ________

☐ Surveillance swab sent (if indicated)

Medication Reconciliation completed for same day admission.
Best Possible Medication History completed for day surgery patient with chronic renal failure on hemodialysis.

1. Legal Name: ________ SURNAME ________ MIDDLE ________ FIRST ________ PREFERRED NAME
2. How old are you? ____________
3. Home #: ____________ Cell #: ____________ Alternate #: ____________
4. Date of Surgery(DD/MMM/YYYY): ____________ Surgeon's Name ____________
   Type of Surgery: ____________
5. Do you have a Health Care Directive? ☐ No ☐ Yes ☐ Copy attached
6. What language do you speak/understand? ☐ English ☐ French ☐ Other: ________
   Will you need an interpreter? ☐ No ☐ Yes
7. Contact Person: ____________ Relationship: ____________ Phone #: ____________
   Alternate #: ____________
8. Who will pick you up from the hospital on discharge?
   Name: ____________ Relationship: ____________ Phone #: ____________
   Alternate #: ____________
9. Have you been hospitalized for more than 24 hours or spent more than 24 hours in an Emergency Department in the past 6 months?
   a. ☐ In an acute care hospital within Manitoba ☐ Other: ____________
   b. Have you been hospitalized or investigated for the following in the past 6 months?
   ☐ Tuberculosis (TB) ☐ C. difficile ☐ MRSA Other: ________ ☐ Do not know
10. Do you have allergies and/or intolerances (ie: medication, latex, tape, dust/pollen, food, etc)?
    ☐ No ☐ Yes (list below)

Allergic To	Reaction

11. Do you wear a Medic Alert® Bracelet ? ☐ No ☐ Yes
    What does it say? ____________
12. Are your immunizations up to date? ☐ No ☐ Yes
13. List home medications or attach a copy of your medication list
    Prescription medications (i.e.: birth control pills, creams, eye drops, inhalers, insulins, patches, sleeping pills, etc)
    Over the counter medications (i.e.: aspirins, cold/allergy drugs, laxatives, vitamins, herbs or others (ie: gingkobiloba, St. John's Wort, etc.)

Drug Name	Dose (grams or mg)	How Often	Reason

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

Patient Name: ____________ **PHIN:** ____________

14. Family Doctor's Name: ____________________ Phone #: ____________
Date of last visit: (DD/MMM/YYYY) Reason: ____________________

15. Do you see a Specialist Doctor (heart, lung, blood, etc)? ☐ No ☐ Yes – list below
Doctor's Name: ____________________ Phone #: ____________
Date of last visit: (DD/MMM/YYYY) Reason: ____________________
Doctor's Name: ____________________ Phone #: ____________
Date of last visit: (DD/MMM/YYYY) Reason: ____________________

16. Is it possible that you could be pregnant? ☐ No ☐ Yes

17. How tall are you? ____________ How much do you weigh? ________ lbs or kgs

18.
a) Do you have Obstructive Sleep Apnea (OSA)? ☐ No ☐ Yes
b) Have you had a sleep study? ☐ No ☐ Yes
c) Do you use a CPAP / BiPAP machine? ☐ No ☐ Yes
d) Do you snore loudly (enough to be heard through closed doors)? ☐ No ☐ Yes
e) Do you think you have abnormal or excessive sleepiness during the day? ☐ No ☐ Yes
f) Has anyone noticed that you momentarily stop breathing during your sleep? ☐ No ☐ Yes
g) Is your neck measurement greater than 40 cm / 16 inches? ☐ No ☐ Yes

19. Do you get short of breath or tightness in your chest lying flat in bed or getting dressed? ☐ No ☐ Yes
Can you climb 1 flight of stairs without stopping to rest? ☐ No ☐ Yes ☐ Haven't tried this activity

20. Health History: Place a mark (X) if you have had any of these. ☐ None

- ☐ Chest Pain
- ☐ Angina/Heart Related Chest Pain
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart bests faster, Skipped beats
- ☐ Rheumatic fever
- ☐ High Blood Pressure
- ☐ Implanted electronic devices (pace-maker, internal defibrillator, internal pain stimulator) Date of last visit: (DD/MMM/YYYY)
- ☐ Persistent swelling in legs and/or feet
- ☐ Transient Ischemic attack (TIA) mini stroke
- ☐ Blackouts/fainting spells in last year
- ☐ Blood transfusion Date: (DD/MMM/YYYY)
- ☐ Seizures
- ☐ Blood clots: (legs, lungs, pelvis)
- ☐ Family history of blood clots
- ☐ Stroke

- ☐ Parkinson's Disease/tremors
- ☐ Muscle disease
- ☐ Joint/bone problems (arthritis)
- ☐ Frequent heart burn/acid reflux
- ☐ Lung Problems
- ☐ Shortness of breath, cough
- ☐ Asthma
- ☐ Wheeze
- ☐ Home oxygen
- ☐ Hepatitis/Jaundice/Liver Disease
- ☐ Bowel disease (Crohn's Colitis)
- ☐ Kidney/bladder problems
- ☐ Hemodialysis: date of last treat-ment: (DD/MMM/YYYY)
- ☐ Peritoneal dialysis: date of next treatment: (DD/MMM/YYYY)
- ☐ Pseudo cholinesterase Deficiency
- ☐ Disease of nervous system (MS)
- ☐ Malignant Hyperthermia
- ☐ Other:

- ☐ Anemia/low iron
- ☐ Chronic Pain
- ☐ Gout
- ☐ Bleeding disorders
- ☐ Sickle Cell Disease
- ☐ Ulcers
- ☐ Open wounds
- ☐ Skin rashes
- ☐ Migraines/headaches
- ☐ Glaucoma
- ☐ Thyroid problems
- ☐ Mental health issues
- ☐ Dementia
- ☐ Depression
- ☐ Anxiety/panic attacks
- ☐ Diabetes
- ☐ Cancer
- ☐ HIV / AIDS
- ☐ Recent memory loss

Hospital Use Only

Interview Information

Known OSA
(PAC referral required)

If 17 b-g questions are Yes (PAC referral required)

Patient Name: ______________________ **PHIN:** ______________

Comments: ______________________

Are there health problems that run in your family? ………………………………….. ☐ No ☐ Yes

Explain: ______________________

Have you ever had an anesthetic? …………………………………………………. ☐ No ☐ Yes

Have you ever had a problem with anesthetic? ……………………………………….. ☐ No ☐ Yes

Explain: ______________________

Has anyone in your family ever had a problem with an anesthetic? ………………... ☐ No ☐ Yes

Explain: ______________________

21. List any operations (surgery) you have had:

Operation	Date (DD/MMM/YYYY)	Hospital

The last time you had surgery, did you experience confusion, hallucination or behavior that was unusual for you? ……………………………………………………………………………... ☐ No ☐ Yes

22. Have you been admitted to hospital for any reason other than surgery? ☐ No ☐ Yes

Reason	Date (DD/MMM/YYYY)	Hospital

23. List any special tests you have had:

☐ Stress Test ☐ Ultrasound ☐ Angiogram ☐ Other

Test	Date (DD/MMM/YYYY)	Hospital

24. Transfusion History:

a) Do you have a rare blood type or been told you have antibodies? ………………….. ☐ No ☐ Yes

b) Do you object to blood and blood product transfusion for any reason? ……………... ☐ No ☐ Yes

c) Have you ever received blood or blood products? …………………………………….. ☐ No ☐ Yes

d) Did you have any problems? ……………………………………………………….. ☐ No ☐ Yes

25. Do you smoke? ………….. ☐ No ☐ Yes Do you vaporize? ……………... ☐ No ☐ Yes

How many per day? ______________ Number of years smoked / vaporized? ______________

When did you quit? ______________

26. Do you drink beer / wine / liquor? ☐ No ☐ Yes How much? __________ How often? __________

27. Do you use recreation drugs? ☐ No ☐ Yes Type: __________ How often? __________

Hospital Use Only

Interview Information

Mini-Cog Score (if Available) __________

☐ Not available

For patients greater than 65 years of age,

Flag at risk for delirium if:

☐ Greater than 80 years of age

☐ Benzodiazipines and/or alcohol greater than 3x/week

☐ glasses and/or hearing aides

☐ Mini mental status exam less than 24 or previous delirium

☐ Assistance with any activities of daily living

Delirium Risk flags: __________ /5

If 2 or more flags are present, implement facility protocol.

☐ N/A patient less than 65 years of age

Patient Name: ______________________ **PHIN:** ______________________

28. Do you have:
☐ Capped or lose teeth ☐ Dentures/removable bridge work - ☐ upper ☐ lower
☐ Contact lenses ☐ Hearing aid - ☐ right ☐ left
☐ Eyeglasses ☐ Body piercings: ______________
☐ Prosthesis, specify: ______________

29. Nutrition Status: ☐ Regular diet
a) Special diet? ………………………… ☐ No ☐ Yes
Type of diet: ______________
Describe eating pattern: ______________
b) Difficulty eating or swallowing? ………………………… ☐ No ☐ Yes
c) Weight pattern: ☐ Stable ☐ Gain ☐ Loss - Amount: ________ Time period: ________
☐ Nausea ☐ Vomiting ☐ Choking ☐ Indigestion ☐ Reflux ☐ Anorexia

30. Elimination Status: ☐ Regular ☐ Ostomy ☐ No Concerns
a) Urinary pattern: ☐ Urgency ☐ Incontinent ☐ Frequency ☐ Get up during the night
Describe urinary pattern: ______________
b) Bowel pattern: ☐ Diarrhea ☐ Constipation ☐ Incontinent
Describe bowel pattern: ______________
c) Other? ………………………… ☐ No ☐ Yes
Describe: ______________

31. Functional Status: ☐ No concerns
a) Any changes in activities of daily living? ………………………… ☐ No ☐ Yes
Explain: ______________

All Surgery Patients:
b) Fall within 6 months? ………………………… ☐ No ☐ Yes
c) Do you require assistance with toileting, bathing, dressing, walking, and feeding? ☐ No ☐ Yes
Explain: ______________
d) Do you use any of these: ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair
☐ Scooter ☐ Bathroom assists ☐ Mechanical lifts
Explain: ______________
e) Any changes in sleep pattern? ………………………… ☐ No ☐ Yes
Explain: ______________
f) Do you have any pain? ………………………… ☐ No ☐ Yes
Explain: ______________

32. What are your living arrangements? ☐ No concerns
a) Live: ☐ Alone ☐ Spouse/partner ☐ Children ☐ Pets ☐ Other: ________
b) Residence: ☐ Apartment ☐ House ☐ Group Home ☐ Personal Care Home
☐ Supportive Housing ☐ Assisted Living
c) Must use stairs: ☐ No ☐ Yes Number: ______ Is there a railing? ☐ No ☐ Yes

33. Are you using any community services right now? ☐ No Services
☐ Home Care ☐ Physiotherapy ☐ Occupational Therapy ☐ Dietitian
☐ Day Hospital ☐ Lifeline® ☐ Handi-transit ☐ Other: ________
☐ Treaty Number: ________ ☐ Band Name: ________
☐ Social Assistance: Case Worker Name: ________ Phone #: ________ Case # ________

34. Who completed this form? ☐ Patient ☐ Other: Name/Relationship: ______________

Hospital Use Only
Interview Information

☐ Consults Initiated

☐ If one or more of The risk for Falls Questions (31b,c or d) is checked yes, complete the Falls Risk Assessment & Interventions

Completed by:

Date: (DD/MMM/YYYY)

Time:

Thank you for taking the time to complete this questionnaire.

Patient Questionnaire is valid for 6 months, provided there has been significant change in the patient's condition.