JOSEPH BRANT HOSPITAL

Preoperative Patient Questionnaire

I am coming into the hospital for:

☐ Surgery ☐ Childbirth ☐ Other: _____

Do you have any Allergies?

☐ Yes ☐ No If so, indicate: _____

Date (dd/mm/yy): _____

Patient's Last Name:	First Name:	
Address	Street:	
City:	Province:	Postal Code:
Health Card Number	Age:	Sex: ☐ M ☐ F
Patient's Birthdate (dd/mm/yy)		
Patient's height	Patient's weight:	

HAVE YOU HAD PREVIOUS OPERATIONS (INCLUDE CHILDBIRTH)? IF YES, LIST BELOW.

Operations	Anaesthetic type, if known *General/spinal/epidural/local*	Hospital	Anaesthetic problems

ANAESTHETIC HISTORY

Have you or any blood relatives in your family ever had a bad reaction to an anaesthetic? ◯ Yes ◯ No

Is there family history of Malignant Hyperthermia (high fever) during anaesthetic? ◯ Yes ◯ No

Have you ever been told of difficulty with placement of breathing tube during anaesthetic? ◯ Yes ◯ No

Do you have pain/stiffness in your neck/jaw (TMJ)? ◯ Yes ◯ No

Do you have pain/stiffness in your Lower back? ◯ Yes ◯ No

Do you have any loose teeth, capped teeth, braces, retainers or dentures? ◯ Yes ◯ No

Do you have difficulty opening your mouth fully? ◯ Yes ◯ No

HEART AND STROKE

Do you have any heart problems? If YES, please select all that apply: ◯ Yes ◯ No

☐ Heart attack ☐ Angina ☐ Valve Problems ☐ Atrial Fibrillation ☐ Congestive Heart Failure ☐ Other _____

Have you ever had any heart procedures? If YES, please select all that apply: ◯ Yes ◯ No

☐ Coronary Stent ☐ Valve Surgery ☐ Bypass ☐ Other _____

Have you ever had blackouts or fainting spells? ◯ Yes ◯ No

Do you have a pacemaker or defibrillator? ◯ Yes ◯ No

Have you ever been told you have an aneurysm? ◯ Yes ◯ No

Do you take medications for high blood pressure? ◯ Yes ◯ No

Have you ever had numbness, tingling, or weakness in your arms or legs? ◯ Yes ◯ No

Have you ever had a stroke or mini-stroke? ◯ Yes ◯ No

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BLOOD

Do you or any family member have any blood problems? If YES, please select all that apply. ○ Yes ○ No

☐ Anemia ☐ Sickle Cell Disease ☐ Abnormal Bleeding ☐ Blood Clots ☐ Other _____

BREATHING

Do you have any breathing problems? If YES, please select all that apply: ○ Yes ○ No

☐ Chronic Cough ☐ Asthma ☐ Bronchitis ☐ Emphysema/COPD ☐ TB

☐ Pneumonia ☐ Asthma ☐ Shortness of Breath ☐ Snore loudly ☐ Other _____

Are you on home oxygen therapy? ○ Yes ○ No

Do you or have you ever smoked (tobacco/marijuana)? ○ Yes ○ No

If you have quit, when did you quit? _____ If you smoke, how many times per day? _____

Have you taken any steroids by mouth in the last 6 months? ○ Yes ○ No

Do you often feel Tired, Fatigue or Sleepy during the daytime? ○ Yes ○ No

Has anyone Observed you Stop Breathing or Choking / Gasping during your sleep? ○ Yes ○ No

Have you ever been told you have sleep apnea? ○ Yes ○ No

Do you use a CPAP machine? ○ Yes ○ No

BRAIN/ NERVE

Have any of the following problems? If YES, please select all that apply: ○ Yes ○ No

☐ Multiple Sclerosis ☐ Myasthenia Gravis ☐ Muscular Dystrophy ☐ Parkinson's disease

☐ Seizures ☐ Peripheral Neuropathy ☐ Sciatica ☐ Other _____

RENAL/ENDOCRINE

Do you have Diabetes? If Yes, please select all that apply ○ Yes ○ No

☐ Borderline ☐ Diet ☐ Pills ☐ Insulin

Do you have kidney problems? ○ Yes ○ No

Are you on Dialysis? If Yes, please select all that apply ○ Yes ○ No

☐ Hemodialysis ☐ Peritoneal dialysis

Do you have thyroid problems? ○ Yes ○ No

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OTHER

Do you have a history of Mental Health Issues? Please select all that apply — ◯ Yes ◯ No

☐ Depression ☐ Anxiety ☐ Other _____

Do you use any ambulatory aids? Please select all that apply — ◯ Yes ◯ No

☐ Wheelchair ☐ Walker ☐ Cane

Have you ever been told you have HIV or AIDS? — ◯ Yes ◯ No

Do you have any autoimmune disorders? Please select all that apply — ◯ Yes ◯ No

☐ Lupus ☐ Rheumatoid Arthritis ☐ Scleroderma ☐ Fibromyalgia ☐ Other _____

Have you ever had cancer? If Yes, please select all the treatments that apply — ◯ Yes ◯ No

☐ Radiation ☐ Chemotherapy ☐ Other _____

Do you suffer from chronic pain? — ◯ Yes ◯ No

Are you taking pain killers regularly? — ◯ Yes ◯ No

Do you drink alcohol? If yes – How many drinks per week _____ — ◯ Yes ◯ No

Do you take recreational drugs? (E.g.: cocaine, heroin, marijuana) — ◯ Yes ◯ No

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What additional health issues / concerns should we be aware of before your surgery?

If you have seen any specialists (example: Cardiologist, Respirologist) in the last year, please list below:

Name of specialist or physician	**Telephone /Fax Number**

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PLEASE LIST ALL MEDICATIONS YOU TAKE INCLUDING:

Prescription / Vitamins / Supplements / Diet Pills / Herbal / Over the counter products

Medication	**Dose** (Strength)	**How Often Taken**	**When** (E.g. morning)

If you are going to the Pre-Op Clinic, please bring all your prescription medication containers and non-prescription medication containers.

IMPORTANT WARNING REGARDING DENTAL DAMAGE

During the administration of your anaesthetic and during the recovery period immediately following your operation it may be necessary to suction secretions from your mouth and to place breathing tubes and plastic airways in your mouth to assure clear breathing. All possible precautions and care are taken to avoid damage to your teeth and dental prosthesis. There is always a possibility for your teeth and dental prosthesis to be damaged in the Operating Room or Recovery Room. It is a recognized risk of anaesthetics and recovery. The personnel performing these procedures shall not be held accountable for expenses related to replacement or repair of any dental damage. Please discuss your concerns, if any, with the anaesthetist prior to your operation.

I have read and understand the above ◯ Yes ◯ No Initial _____

Signature of Person Completing: _____ Date: _____