### Preoperative Patient Questionnaire - Adult

**Date (yyyy/mm/dd)**

**Surgery**

**Name of person completing this form (if not the patient)**

**Relationship to patient**

**Name patient likes to be called**

<table>
<thead>
<tr>
<th>Previous operations and / or hospital stays</th>
<th>Date (yyyy/mm/dd)</th>
<th>Previous operations and / or hospital stays</th>
<th>Date (yyyy/mm/dd)</th>
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<tr>
<td>1.</td>
<td>6.</td>
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</table>

**Have you ever had an anesthetic?**
- No
- Yes

**Have you had any problems with anesthesia such as unusual temperature changes or trouble breathing?**
- No
- Yes

**Do you have a blood relative who has had any problems with anesthesia such as unusual temperature changes or trouble breathing?**
- No
- Yes

**Mouth**

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

- Do you have dentures?
  - No
  - Yes
  - (Upper: Full, Partial)
  - Yes
  - (Lower: Full, Partial)

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

- Do you have pain or difficulty when you move your neck?
- No
- Yes

**Heart and Stroke**

- Do you have high blood pressure or do you take medication for high blood pressure?
  - No
  - Yes

- Do you have high cholesterol or do you take medication for high cholesterol?
  - No
  - Yes

- Have you ever had angina or chest pain?
  - No
  - Yes

- Have you ever had a heart attack?
  - No
  - Yes

- Have you ever had heart failure?
  - No
  - Yes

- Have you ever had an irregular heart beat?
  - No
  - Yes

- Do you have a pacemaker or an implantable defibrillator?
  - No
  - Yes

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

- Have you ever had a blood clot?
  - No
  - Yes

- Can you walk up two flights of stairs without stopping?
  - No
  - Yes
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Have you arranged with your surgeon's office to donate your own blood for surgery?</td>
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<td>Would you have any objection to receiving blood products if necessary?</td>
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<td>Have you ever had a blood transfusion?</td>
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<td>Have you ever been anemic or been told you have low iron?</td>
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<td>Have you ever been told that you have a bleeding disorder?</td>
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<td>Have you ever been tested for any mental illness?</td>
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<td>Do you have a disease that affects your muscles or nerves?</td>
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<td>Have you ever been diagnosed with epilepsy, seizures or learning difficulties?</td>
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<td>Do you have thyroid problems?</td>
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<td>Do you have diabetes?</td>
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<td>Do you have kidney disease?</td>
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<td>Have you ever been told that you have hypertension?</td>
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<td>Have you ever been told that you have a hiatus hernia?</td>
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<td>Have you ever been diagnosed with Bronchiectasis?</td>
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<td>Have you ever been told that you have tuberculosis, emphysema or chronic</td>
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<td>Have you ever been told that you have asthma?</td>
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<td>Do you use a C-Pap or Bi-Pap machine regularly at home?</td>
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<td>Have you ever been told that you have sleep apnea?</td>
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<td>Have you ever been told that you stop breathing while you are asleep?</td>
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<td>Do you snore loud enough to be heard from another room?</td>
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<td>Do you use oxygen at home?</td>
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<td>Do you currently have a cough with mucus or sputum?</td>
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<td>Do you have trouble with your breathing during exercise?</td>
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<td>Do you have trouble with your breathing with normal activity?</td>
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<td>Number of cigarettes a day</td>
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<td>Number of years</td>
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<td>When did you quit?</td>
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<td>Have you ever smoked?</td>
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<tr>
<td>Do you currently smoke?</td>
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Date: (yyyy/mm/dd)

Patient's Gender (M/F): __________ Sex: __________ Age: __________

Patient's Last Name: __________ First Name: __________

Questionnaire - Adult - Prophylactic Patient
Preoperative Patient Questionnaire - Adult

Date: (yyyy/mm/dd)

Infectious Disease
Have you ever been told you have HIV or AIDS? □ No □ Yes
Have you ever been told you have hepatitis? □ No □ Yes

Do you take prescription medication for chronic pain? □ No □ Yes

Do you drink alcohol? □ No □ Yes → How many drinks per week

Do you use recreational or street drugs? □ No □ Yes

Do you have any cultural or religious practices that we should be aware of while you are in the hospital? □ No □ Yes

Female Patients Only
Could you be pregnant at this time? □ No □ Yes □ N/A
Date of last Menstrual period (yyyy/mm/dd)

What other health issues should we be aware of before your surgery?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Adult Preoperative Patient Questionnaire Reviewed By:

________________________________________  __________  __________
Printed Name  Signature & Designation  ( yyyy / mm / dd )

________________________________________  __________  __________
Printed Name  Signature & Designation  ( yyyy / mm / dd )

________________________________________  __________  __________
Printed Name  Signature & Designation  ( yyyy / mm / dd )
Please bring all your prescription medication containers and non-prescription medication containers with you to the Pre-Op Clinic.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Strength</th>
<th>Dose</th>
<th>When Taken</th>
<th>How Often</th>
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</table>

Please list all medications you take including:
- Prescription
- Over the counter products
- Eye / Ear drops
- Nasal Mists
- Vitamins / Supplements
- Dial Pill
- Herbal
- Prescription - including inhalers (puffers), insulin and patches

Date: (yyyy/mm/dd)

Patient's Birthdate (yyyy/mm/dd): Age: Sex: M F

Preoperative Patient Questionnaire - Adult

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