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>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>6.</td>
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<td>5.</td>
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<td>10.</td>
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</tbody>
</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)

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
### Preoperative Patient Questionnaire - Adult

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

#### Patient's Information
- Patient's Last Name
- Patient's First Name
- Patient's Birthdate (yyyy/mm/dd)
- Age
- Sex: □ M □ F

#### Smoke
- **Do you currently smoke?** [ ] No [ ] Yes
  - Number of cigarettes a day ___
  - Number of years ___

- **Have you ever smoked?** [ ] No [ ] Yes
  - When did you quit? __________________________
  - Number of cigarettes a day ___
  - Number of years ___

#### Breathing
- **Do you currently have a cough with mucous or sputum?** [ ] No [ ] Yes
- **Do you use oxygen at home?** [ ] No [ ] Yes
- **Do you snore loud enough to be heard from another room?** [ ] No [ ] Yes
- **Have you ever been told that you stop breathing while you are asleep?** [ ] No [ ] Yes
- **Have you ever been told that you have sleep apnea?** [ ] No [ ] Yes
- **Do you use a C-Pap or Bi-Pap machine regularly at home?** [ ] No [ ] Yes
- **Have you ever been told that you have asthma?** [ ] No [ ] Yes
- **Have you ever been told that you have tuberculosis, emphysema or chronic bronchitis?** [ ] No [ ] Yes

#### Liver / Stomach
- **Have you ever been jaundiced (yellow colour of your skin)?** [ ] No [ ] Yes
- **Do you have frequent heartburn?** [ ] No [ ] Yes
- **Have you ever been told that you have a hiatus hernia?** [ ] No [ ] Yes
- **Have you ever been told that you have ulcers?** [ ] No [ ] Yes

#### Renal / Endocrine
- **Do you have kidney disease?** [ ] No [ ] Yes
- **Do you have diabetes?** [ ] No [ ] Yes
- **Do you have thyroid problems?** [ ] No [ ] Yes

#### Brain / Nerve
- **Have you ever been diagnosed with epilepsy, seizures or fainting spells?** [ ] No [ ] Yes
- **Do you have a disease that affects your muscles or nerves?** [ ] No [ ] Yes
- **Have you ever been treated for any mental illness?** [ ] No [ ] Yes

#### Blood
- **Have you ever been told that you have a bleeding disorder?** [ ] No [ ] Yes
- **Have you ever been anemic or been told you have low iron?** [ ] No [ ] Yes
- **Have you ever had a blood transfusion?** [ ] No [ ] Yes
- **Would you have any objection to receiving blood products if necessary?** [ ] No [ ] Yes
- **Have you arranged with your surgeon's office to donate your own blood for surgery?** [ ] No [ ] Yes
### Preoperative Patient Questionnaire - Adult

<table>
<thead>
<tr>
<th><strong>Infectious Disease</strong></th>
<th><strong>Have you ever been told you have HIV or AIDS?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td></td>
<td><strong>Have you ever been told you have hepatitis?</strong></td>
</tr>
<tr>
<td></td>
<td>□ No □ Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Other</strong></th>
<th><strong>Do you take prescription medication for chronic pain?</strong></th>
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<tbody>
<tr>
<td></td>
<td>□ No □ Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Do you drink alcohol?</strong></th>
<th>□ No □ Yes  ➔ <strong>How many drinks per week</strong></th>
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<tbody>
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<table>
<thead>
<tr>
<th><strong>Do you use recreational or street drugs?</strong></th>
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<tbody>
<tr>
<td>□ No □ Yes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Do you have any cultural or religious practices that we should be aware of while you are in the hospital?</strong></th>
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<tbody>
<tr>
<td>□ No □ Yes</td>
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**Female Patients Only**

<table>
<thead>
<tr>
<th><strong>Could you be pregnant at this time?</strong></th>
</tr>
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<tbody>
<tr>
<td>□ No □ Yes □ N/A</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Date of last Menstrual period</strong> (yyyy/mm/dd)</th>
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</table>

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

1. 
2. 
3. 
4. 

**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)
# Preoperative Patient Questionnaire - Adult

## Pre Surgery Medication List

<table>
<thead>
<tr>
<th>Patient's Birthdate (yyyy/mm/dd)</th>
<th>Age</th>
<th>Sex [ ] M [ ] F</th>
<th>Date: (yyyy/mm/dd)</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Dose (Strength)</th>
<th>How Often Taken</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Morning (am)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Afternoon (aft)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evening (eve)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bedtime (pm)</td>
</tr>
</tbody>
</table>

Please bring all your prescription medication containers and non-prescription medication containers with you to the Pre-Op Clinic
- including inhalers (puffers) and insulin -