KEMPTVILLE DISTRICT HOSPITAL

Building healthier communities

PRE-OP HEALTH HISTORY PATIENT QUESTIONNAIRE

Dear Patient: Please complete this health history questionnaire to the best of your ability. Your Anesthesiologist will review it prior to your Virtual Consultation.

Required fields are indicated with an asterisk (*)

CPI# (if known) _____

First Name * _____

Last Name * _____

Email Address * _____

Date of Birth * _____

Height (m) * _____

Weight (kg) * _____

Sex ___ Male ___ Female

Proposed Surgery/Procedure (Include L or R limb) _____

_____

Proposed date of Surgery _____

Surgeon _____

Heart Rate (if known) _____

Blood Pressure (if known) _____

ALLERGIES

Do you have allergies to:

Latex? Yes ___ No ___

Describe your symptoms _____

_____

Eggs? Yes ___ No ___

Describe your symptoms _____

Medication? Yes ___ No ___

Indicate which medicine(s) and describe your symptoms_____

_____

_____

Metal? Yes ___ No ___

Describe your symptoms _____

_____

List all of the medications that you take _____

_____

HEART

Do you have:

Any heart problem? (e.g., heart attack, murmur, angina, blockages, angioplasty, stent, valve problems, irregular heartbeat, heart surgery, heart failure). Yes ___ No ___

If yes, elaborate _____

_____

High blood pressure? Yes ___ No ___

Chest pain or breathlessness after climbing 2 flights of stairs? Yes ___ No ___

A pacemaker or an implantable defibrillator? Yes ___ No ___

An artificial heart valve? Yes ___ No ___

Any other heart issues? Yes ___ No ___.

If yes, elaborate _____

_____

Do you smoke tobacco of any kind? (e.g., cigarettes, cigars, pipes). Yes ___ No ___

BLOOD PROBLEMS

Have you ever been treated for:

Anemia (low blood count)? Yes ___ No ___

Blood clots (in your lungs, legs or other)? Yes ___ No ___

A bleeding disease or problem? Yes ___ No ___ If yes, elaborate _____

_____

Do you have any personal or religious reasons for refusing to have any blood products given to you? Yes ___ No ___

BREATHING

Do you have:

Emphysema, chronic obstructive pulmonary disease (COPD) or chronic bronchitis? Yes ___No ___

Asthma? Yes ___ No ___

Sleep apnea? (diagnosed by a physician) Yes ___ No ___

A breathing machine to help you sleep? Yes ___ No ___

Inhalers (puffers)? Yes ___ No ___

Oxygen at home to help you breathe? Yes ___ No ___

A problem lying flat for at least 30 minutes because of difficulty breathing? Yes ___ No ___

Or ever had, shortness of breath for which you have been admitted to hospital within the last 2 months? Yes ___ No ___ If yes, elaborate _____

_____

NEUROLOGICAL

Do you have/have you had:

Memory problems or confusion? Yes ___ No ___

A history of extreme confusion after an operation? Yes ___ No ___

A stroke or stroke- like symptoms in the past? Yes ___ No ___

Any aneurysm? Yes ___ No ___

Epilepsy or convulsions? Yes ___ No ___

Fainting spells? Yes ___ No ___

OTHER IMPORTANT MEDICAL INFORMATION

Do you have stomach ulcers, heartburn or a hiatus hernia? Yes ___ No ___

Have you had radiation treatment? Or been diagnosed with Cancer? Yes ___ No ___

If yes, elaborate _____

_____

Are you diabetic? Yes ___ No ___

Are you on dialysis? Yes ___ No ___

Do you have kidney disease? Yes ___ No ___

Do you have liver disease? Yes ___ No ___

Do you take Aspirin (ASA) regularly? Yes ___ No ___

Are you on a prescription for blood thinners? (e.g., warfarin, coumadin, plavix, dabigatran, rivaroxaban) Yes ___ No ___

Do you have family (blood relatives) who have had serious problems following an anesthetic?
Yes ___ No ___

If yes, elaborate _____

_____

Have you had serious problems following an anesthetic (e.g., malignant hyperthermia)?
Yes ___ No ___

If yes, elaborate _____

_____

Do you have trouble opening your mouth, jaw or moving your neck? Yes ___ No ___

Do you have a chronic pain disorder? Yes ___ No ___

Is there a possibility that you could be pregnant? Yes ___ No ___

Do you have arthritis? Yes ___ No ___

Do you use any street drugs? Yes ___ No ___

Do you have a hearing impairment or wear a hearing aid? Yes ___ No ___

Do you have any loose teeth or dentures? Yes ___ No ___

Has anyone ever told you that you had a difficult airway? Yes ___ No ___

Have you ever had back surgery? Yes ___ No ___

DISCHARGE PLANNING AND MOBILITY

Do you use a wheelchair, walker, cane, scooter or other aid? Yes ___ No ___

Do you have problems with your balance? Yes ___ No ___

Do you have someone available to stay with you overnight and help care for you?
Yes ___ No ___

Do you live in a retirement home, boarding home or long term care facility, or other?
Yes ___ No ___

List any surgeries or minor procedures using anesthetic you have had in the past. _____

_____

_____

_____

_____