Toronto East General Hospital

# Pre-op Health History Patient Questionnaire

**(PAC Fax # 416-469-6676)**

**Dear Patient:** *Please complete this health history to the best of your ability. Alternatively you can have your Family Physician complete this form. ** It is important to have this health history completed and given to your Surgeon's Office as soon as possible in order to determine whether you require a Pre-Op Consult appointment prior to your surgery***

**Note to offices:** *Patient Health History's are valid for up to 3 months prior to surgical date. If bypassing PAC, please submit no later than 9 days prior to surgery.*

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Patient label here

Print

Patient name:

DOB:

MRN:

DATACM
PROOF #3
July 13.2016

## Part A – GENERAL INFORMATION

**Patient name (please print):** ______________________
Last Name  First  Initial

**Date of birth** ( ____ /____ /____ ) Age: ___________ **Today's Date** ( ____ /____ /____ )
DD MM YYYY

**Surgical Procedure:** ______________ Surgeon: __________________ Surgical Date (if known): ( ____ /____ /____ )
DD MM YYYY

## Part B – PATIENT'S HEALTH HISTORY

| ANAESTHESIA HISTORY - SECTION 1 | Yes | No | COMMENTS (*) Requires PAC |
|---|---|---|---|
| Have you or anyone in your family (i.e. blood relatives) ever had | | | |
| 1. Malignant Hyperthermia after anesthesia or surgery? | ☐ | ☐ | * |
| 2. Do you have any problem opening your mouth or moving your neck? | ☐ | ☐ | * |
| 3. Have you had any head/neck surgery and head/neck radiation? | ☐ | ☐ | * |
| 4. Have you ever been told that you were a "difficult airway"? | ☐ | ☐ | * |
| **HEART HEALTH - SECTION 2** | | | |
| 5. Do you have any heart problems? (Please circle) (eg heart attack, Chest pain or Angina, Blockages, Irregular heartbeat / arrhythmia, Valve problems, heart failure, heart surgery) | ☐ | ☐ | * |
| 6. Do you have a Pacemaker or Implantable Defibrillator? | ☐ | ☐ | * |
| 7. Have you had any recent Echo's or stress tests in the last 2 years? | ☐ | ☐ | If YES, please bring a copy |
| 8. Do you get chest pain or Shortness of Breath after walking two blocks or climbing two flights of stairs? | ☐ | ☐ | * |
| 9. Do you have high blood pressure or take medication for high blood pressure? | ☐ | ☐ | ☐ Not Well Controlled * <br> ☐ Well Controlled |
| 10. Do you see a Cardiologist more than once a year? | ☐ | ☐ | * |
| **CARDIOLOGIST'S** Name: ______________________ | | | |
| Phone: (    ) ______________ Fax: (    ) ______________ | | | |
| **RESPIRATORY HEALTH - SECTION 3** | | | |
| 11. Do you have **SLEEP APNEA**? | ☐ | ☐ | ☐ Use CPAP * <br> ☐ Don't use CPAP * |
| 12. Do you have Asthma? | ☐ | ☐ | |
| 12a. If Yes, do you have asthma attacks more than 1x monthly? | ☐ | ☐ | * |
| 13. Do you have any of the following: (Please circle) (COPD/Emphysema, Flu or Pneumonia (within the last month), Pulmonary Fibrosis, Chronic bronchitis, Breathing problems when lying flat) | ☐ | ☐ | Use Home Oxygen? * <br> Yes ☐ No ☐ |
| 14. Have you needed to visit an emergency department for your breathing in the past 2 months or received Prednisone? | ☐ | ☐ | * |
| **RESPIROLOGIST'S** Name: ______________________ | | | |
| Phone: (    ) ______________ Fax: (    ) ______________ | | | Other: |



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# Pre-Op Clinic Patient Questionnaire

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| ENDOCRINE HEALTH - SECTION 4 | Yes | No | COMMENTS |
|---|---|---|---|
| 15. Do you have diabetes? | ☐ | ☐ | Diet ☐ Pills ☐ |
| 16. Do you require **INSULIN**? | ☐ | ☐ | * |
| 17. Do you use insulin pump? | ☐ | ☐ | * |
| 18. Do you have an overactive thyroid gland? | ☐ | ☐ | * |
| 19. Do you have Adrenal or Pituitary disease? | ☐ | ☐ | * |
| **KIDNEY AND BLADDER HEALTH - SECTION 5** | | | |
| 20. Do you have kidney disease or require dialysis? (not kidney stones) | ☐ | ☐ | * |
| 21. Do you have: ☐ PD catheter ☐ Fistula ☐ Hemodialysis Line | ☐ | ☐ | * |
| **NEPHROLOGIST'S** Name: ______ | | | |
| Phone: ( ) ______ Fax: ( ) ______ | | | |
| **STOMACH AND INTESTINAL HEALTH - SECTION 6** | | | |
| 22. Do you have a hiatus hernia or heartburn (acid reflux)? | ☐ | ☐ | |
| 23. Do you have ☐ Liver Disease ☐ Cirrhosis/Jaundice | ☐ | ☐ | * |
| **NERVE, MUSCLE AND BONE HEALTH - SECTION 7** | | | |
| 24. Do you have or have you ever had any of the following? *(Select all that apply)* | | | date of last episode: (D/M/Y) |
| ☐ Stroke/TIA in the last 6 months ☐ Seizure disorder ☐ Spinal cord problems | | | * |
| 25. Do you have ☐ Dementia/Alzheimer's | | | |
| ☐ Other *(please specify e.g. MS, Myasthenia Gravis and Parkinson's)* ______ | | | * |
| 26. Do you have Arthritis of the NECK ☐ rheumatoid ☐ or osteoarthritis ☐ | | | * |
| 27. Do you have Ankylosing spondylitis ☐ | | | * |
| **NEUROLOGIST'S** Name: ______ | | | |
| Phone: ( ) ______ Fax: ( ) ______ | | | |
| **BLOOD HEALTH - SECTION 8** | | | |
| 28. Do you have or have you had any of the following? | | | |
| ☐ Blood transfusion for anemia ☐ Sickle cell anemia | | | * |
| ☐ A blood clot (in lungs, legs, or elsewhere) ☐ Bleeding problems | | | * |
| 29. Do you have Sickle Cell Trait? | ☐ | ☐ | |
| 30. Are you on Blood Thinners eg. Coumadin, Pradaxa | ☐ | ☐ | * |
| **HAEMATOLOGIST'S** Name: ______ | | | |
| Phone: ( ) ______ Fax: ( ) ______ | | | |

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## OTHER IMPORTANT MEDICAL INFORMATION – SECTION 9

Important

| | Yes | No | |
|---|---|---|---|
| 31. Have you ever had cancer? | ☐ | ☐ | |
| 31a. If yes, When ______________ / Type ______________ | | | |
| 32. Have you had radiation OR Chemotherapy? | ☐ | ☐ | Last treatment: D/M/Y |
| **ONCOLOGIST'S** Name: ______________________________ | | | |
| Phone: (     ) ______________ Fax: (     ) ______________ | | | |
| 33. Do you have a vascular access line in place? | ☐ | ☐ | |
| ☐ Hickman ☐ PICC ☐ Portacath | | | |

**If you have listed a specialist in section 2 through 9 of this document do we have your permission to contact them and request your consultation notes?** ☐ **Yes** ☐ **No**

| **OTHER:** | | | |
|---|---|---|---|
| 34. Have you had an exposure to a contagious disease? (ie. Hepatitis, TB, HIV.) | ☐ | ☐ | Specify disease: |
| 35. Do you have a history of MRSA/VRE? | ☐ | ☐ | |
| 36. Do you smoke? | ☐ | ☐ | How many per day? |
| 37. Do you use any street drugs *(including marijuana)*? | ☐ | ☐ | |
| 37a. If yes, which drug/s and how often? ______________ | | | |
| 38. Do you drink alcohol? | ☐ | ☐ | # of glasses per week? |
| 39. Do you have a mental illness? | ☐ | ☐ | ☐ Schizophrenic ☐ Bipolar |
| 40. Possibility you could be pregnant? ☐ N/A | ☐ | ☐ | |
| 41. Do you have a disability related to hearing or vision? | ☐ | ☐ | |
| 42. Do you wear hearing aide(s)? (if yes, please wear them for every hospital visit) | ☐ | ☐ | |
| 43. Do you have any open sores? | ☐ | ☐ | If yes, where? |
| 44. Have you had Unintentional weight loss (10 lbs. or more in the past two months?) | ☐ | ☐ | |

**Person completing this form please print/sign name:** ______________________ **Date:** ***D/M/Y*** ________

**Other (Relationship):** ______________________________ **Date:** ***D/M/Y*** ________

List all previous surgeries/procedures in the last 10 years *(please include the year, starting from the most recent)*

| Surgery/Procedure | Year | COMMENTS |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

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# Pre-Op Clinic Patient Questionnaire

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## ALLERGIES (Please list all allergies and intolerances to medications/food/environmental)

Do you have a **PENICILLIN ALLERGY?** ☐ Yes ☐ No

Have you been **ALLERGY TESTED for penicillin?** ☐ Yes ☐ No

Do you have a **LATEX ALLERGY?** ☐ Yes ☐ No

**ALLERGIES** (Please list all allergies and intolerances to medications/food/environmental)

| Allergic to: | Reaction: |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

## COMMENTS

Your approximate weight in kgs __________ or lbs __________

Your approximate height cm ________ or inches __________

## MEDICATIONS (*please list **all** prescription medications, puffers, eye drops non-prescription medications, vitamins/herbal supplements etc.*)

| Medication Name (Please list in the order shown above) | Dosage | What times do you take your meds? (please check ✓) AM | PM | Other | Why do you take it? | Hospital Use Only – Instructions before Surgery: Stop Date before surgery | Hold day of surgery | Continue and Take day of surgery |
|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |
| 7. | | | | | | | | |
| 8. | | | | | | | | |
| 9. | | | | | | | | |
| 10. | | | | | | | | |
| 11. | | | | | | | | |
| 12. | | | | | | | | |
| 13. | | | | | | | | |

Name of your pharmacy:

Phone: Fax:

**PAC USE ONLY:**

Reviewed By: ______________________ Date: ______________ (D/M/Y)

Reviewed By: ______________________ Date: ______________ (D/M/Y)

Approved Appt. Type: __________ ☐ RN Only ☐ M/C ☐ A/C ☐ OTN ☐ Bypass (By Dr. ______________)



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