HURON PERTH HEALTHCARE ALLIANCE

Clinton Public Hospital
St. Marys Memorial Hospital
Seaforth Community Hospital
Stratford General Hospital

HURON PERTH HEALTHCARE ALLIANCE

PAGE 1 PRE-OPERATIVE/PRE-PROCEDURAL PATIENT QUESTIONNAIRE

Instructions: Please read all questions carefully and respond by placing a check (√) in the "yes" or "no" box. For a "yes" response provide additional information in the "describe" section, including the date the problem was diagnosed and any medications, treatments, or hospital stays you have required for the problem.

	YES	NO	DESCRIBE
1. Have you ever had a heart attack, chest pain, angina or chest tightness?			
2. Have you ever had heart failure or fluid in your lungs?			
3. Do you have a heart murmur or valve problem?			
4. Have you ever been treated for an irregular heart beat?			
5. Do you have high blood pressure?			
6. Do you have asthma?			❑ Use inhalers Occasionally ❑ Use inhalers Regularly ❑ On Prednisone
7. Do you cough frequently or have bronchitis or emphysema?			
8. Does climbing one flight of stairs or walking one city block make you short of breath?			
9. Do you now or have you recently smoked cigarettes? If yes, how many packs per day? ____ For how many years? ____			
10. Do you have sleep apnea?			
11. Do you have liver disease, or a history of jaundice or hepatitis?			
12. Do you drink more than three drinks of alcohol per day? If yes, how many per week? _____			
13. Do you have indigestion, heartburn, or a hiatus hernia?			
14. Do you have a history of thyroid problems?			
15. Do you have diabetes?			❑ Diet Controlled ❑ On Pills ❑ On Insulin
16. Do you have a kidney problem?			
17. Do you have numbness or weakness of your arms or legs?			

*** PLEASE COMPLETE BOTH PAGE 1 & 2 ***

PAGE 2 PRE-OPERATIVE/PRE-PROCEDURAL PATIENT QUESTIONNAIRE (cont'd)

	YES	NO	DESCRIBE
18. Have you had epilepsy, blackouts, seizures or a stroke?			
19. Have you had problems with blood clots, or excessive bleeding?			
20. Do you have any other important medical problems? – Please list:			
21. Have you ever had an anesthetic?			
22. Has your health changed since your last anesthetic?			
23. Have you or any member of your family had a reaction to an anesthetic or the placement of the breathing tube?			
24. Do you have neck or jaw pain or arthritis?			
25. Do you have dentures, capped or loose teeth?			
26. Is there any possibility you may be pregnant?			
27. Have you taken prednisone, steroid meds or cortisone-like drugs in the past year?			
28. Would you refuse a blood transfusion as a life-saving procedure?			
29. If this is the day of surgery, when did you last eat or drink?			

Allergies: _____

_____

_____

What MEDICATIONS are you taking regularly?
(including "puffers", eye drops, herbal remedies. Vitamins, etc)

NAME	Dosage	How Often

What OPERATIONS have you had? (List most recent first)	YEAR

30. **Age:** _____ **Weight:** _____ **(kg)** **Height:** _____ **(cm)** **Sat/O2:** _____
BP: _____/_____ **TEMP:** _____ **PULSE:** _____ **RESP.RATE:** _____ **min**

DATE (yy/mm/dd): _____ **PATIENT'S SIGNATURE:** _____

DATE (yy/mm/dd): _____ **REVIEWED BY:** _____