Lake of the Woods District Hospital

SURGICAL SERVICES

PEDIATRIC PATIENT ASSESSMENT QUESTIONNAIRE

Dear Patient/Parent

The purpose of this questionnaire is to assist Surgical Services in creating a positive and safe surgical experience for you. To meet this objective, we need you to answer these questions. Mail, fax (807-468-6794), or drop off, your completed questionnaire at least 2 weeks prior to your surgery to:

Attention: Surgical Services - Pre-Op Clinic
c/o Lake of the Woods District Hospital
21 Sylvan Street West
Kenora, Ontario
P9N 3W7

Should you have any questions please call:
Pre-Op Clinic at 807-468-9861 ext 2459

SURGEON: ____

PROCEDURE: ____

DEMOGRAPHIC INORMATION:

NAME (Last) ________________________

(Given) ________________________

(Used) ________________________

DATE OF BIRTH (y/m/d) ________________________ SEX: (circle) **F** **M**

LIVES WITH PARENT(S) (circle) **YES** **NO**

GUARDIAN (circle) **YES** **NO**
Name: ___________________ *Phone #* ______________

IN CARE (circle) **YES** **NO**
Alternate Phone # ______________________

FAMILY PHYSICIAN __________________________________

LANGUAGE UNDERSTOOD ____________________________

NAME: ____

STATE OF HEALTH:

IMMUNIZATION HISTORY: DPTP _________ MMR _________

Any other immunizations? (circle) **YES** **NO**

COMMUNICABLE DISEASES:

Red Measles	(circle)	**YES**	**NO**
Chicken Pox	(circle)	**YES**	**NO**
Pertussis	(circle)	**YES**	**NO**
German Measles	(circle)	**YES**	**NO**

SURGERIES: (List all surgeries patient has had) None

SURGERY	YEAR

Have there been any problems in the past with anesthesia? (circle) **YES** **NO**

Type: ____

Any blood relatives with anesthesia problems? (circle) **YES** **NO**

Type: ____

ALLERGIES:

(circle) **None** **Environmental** **Tape** **Latex** **Medications**

ALLERGY	REACTION

MEDICATIONS

(List all present medications – prescription, over-the-counter, vitamins and herbs):

DRUG NAME	DOSE	HOW MANY TIMES A DAY

Do you use street drugs? (circle) **YES** **NO**

Drug(s) name How much & how often _____________________________________

Do you drink alcohol? (circle) **YES** **NO**

If YES: How much & how often _____________________________________

NAME: ____

MENTAL HEALTH: (circle) ***No Problems***

Psychiatric Condition(s): (circle) **YES** **NO** ________________________________

Anxiety: (circle) **YES** **NO**

Depression: (circle) **YES** **NO**

COMMUNICATION: (circle) ***No Problems***

Language Barrier: ____________________________________

Need an interpreter (circle) **YES** **NO**

VISION: (circle) ***No Problems***

Glasses: (circle) **YES** **NO**

Contacts: (circle) **YES** **NO**

Specific problem(s): ________________________________

HEARING: (circle) ***No Problems***

Hearing Aid(s): (circle) **YES** **NO**

Left Right Both Don't wear

NEUROLOGICAL: (circle) ***No Problems***

History of stroke/TIA: (circle) **YES** **NO** Deficit(s): __________

Migraines: (circle) **YES** **NO** Last episode: _______

Seizures: (circle) **YES** **NO** Last episode: _______

ENDOCRINE: (circle) ***No Problems***

Diabetes: (circle) **YES** **NO**

Controlled with: Insulin Medication Diet

Thyroid: (circle) **YES** **NO**

Other gland problems: ____________________________________

RESPIRATORY: (circle) ***No Problems***

Smoker: (circle) **YES** **NO**

If YES: How many smokes per day? _______ How long have you smoked? _________

RSV: (circle) **YES** **NO**

Cystic Fibrosis: (circle) **YES** **NO**

Asthma: (circle) **YES** **NO**

Bronchitis: (circle) **YES** **NO**

Pneumonia: (circle) **YES** **NO** **Last episode:** __________

Frequent colds: (circle) **YES** **NO** **Last episode:** __________

Sleep Apnea: (circle) **YES** **NO**

Using CPAP machine (circle) **YES** **NO**

Shortness of breath (circle) **YES** **NO**

NAME: ____

CARDIAC: (circle) ***No Problems***

Heart murmur: (circle) **YES NO**

Heart valve problems: (circle) **YES NO**

Rheumatic fever: (circle) **YES NO**

Irregular heartbeats: (circle) **YES NO**

Palpitations: (circle) **YES NO**

Heart Surgery: (circle) **YES NO** Year: ____________

CIRCULATION: (circle) ***No Problems***

Numbness: (circle) **YES NO** Hands Feet

Tingling: (circle) **YES NO** Hands Feet

Bruise easily: (circle) **YES NO**

Anemia: (circle) **YES NO**

HIV/AIDS: (circle) **YES NO**

Blood clotting disorder: (circle) **YES NO**

History of blood clots: (circle) **YES NO** Year: ____________

Swelling: (circle) **YES NO** Hands Feet Ankles

History of bleeding problems (circle) **YES NO**

History of bleeding problems within family (circle) **YES NO**

REPRODUCTIVE:

***Female*:**

Are you pregnant? (circle) **YES NO**

Possible? (circle) **YES NO**

Total # of pregnancies __________

Living_____ Deceased_____ Miscarriage _____ Abortions _____

Last menstrual period: _____________________

Birth Control: (circle) **YES NO**

GASTROINTESTINAL: (circle) ***No Problems***

Difficulty swallowing: (circle) **YES NO**

Excessive Thirst: (circle) **YES NO**

Vomiting: (circle) **YES NO** Frequency: ________

Sudden Weight Loss (circle) **YES NO**

Indigestion: (circle) **YES NO**

Heartburn: (circle) **YES NO**

Reflux: (circle) **YES NO**

Diarrhea: (circle) **YES NO** Frequency: ________

Blood in stools: (circle) **YES NO** Frequency: ________

Diverticulosis: (circle) **YES NO**

Irritable bowel: (circle) **YES NO**

Constipation: (circle) **YES NO**

Diaper: (circle) **YES NO**

Toilet trained: (circle) **YES NO**

NAME: ____

Bowel pattern: times/day: ____________________

Current weight: _______________ lbs
Current height: _____feet _______ inches

URINARY: (circle) ***No Problems***
Bladder infection(s): (circle) **YES NO** Last episode: ______
Kidney disease: (circle) **YES NO**
Diagnosis: ________________________________

LIVER:
Hepatitis: (circle) **YES NO**
Jaundice: (circle) **YES NO**

MUSCOLSKELETAL: (circle) ***No Problems***
Weakness: (circle) **YES NO**
Upper body: (circle) **YES NO**
Lower body: (circle) **YES NO**
Joint/Muscle problems: (circle) **YES NO**
Chronic Pain: (circle) **YES NO**
Describe: _____________________________
Ambulatory Aids
i.e. cane, walker: (circle) **YES NO**
Describe: __________________________________

SKIN: (circle) ***No Problems***
Skin rashes: (circle) **YES NO**
Diaper rash: (circle) **YES NO**
Eczema: (circle) **YES NO**
Psoriasis: (circle) **YES NO**
Sensitive skin:
Where: ____________________________________

Any other medical condition(s) i.e. Cancer: (circle) **YES NO**
Describe: ____
____

REVIEWED PRE-OPERATIVELY BY: _______________________________________