Lake of the Woods District Hospital

SURGICAL SERVICES
PATIENT ASSESSMENT QUESTIONNAIRE

Dear Patient:

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 *As Soon As Possible (ASAP) 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: _____

DATE ASSESSMENT QUESTIONNAIRE COMPLETED _____

DEMOGRAPHIC INFORMATION

NAME: (Last) _____

(Given) _____

(Used) _____

CONTACT PHONE # _____ CELLPHONE #_____

ALTERNATE PHONE # & NAME _____

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

FAMILY PHYSICIAN _____

LANGUAGE UNDERSTOOD _____

SURGERIES list all surgeries you have had

NAME: _____

SURGERY	YEAR *(if known)*

Are you aware of any problems you have had in the past with anesthesia?
(circle) **YES NO** If yes, what type of problem _____
Do you have any blood relatives with anesthesia problems? (circle) **YES NO**

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 & TIMES

Do you take street drugs? (circle) **YES NO**
Drug name(s) - how much & how often _____

NAME: _____

Do you drink alcohol? (circle) **YES NO**
If yes, how much & how often _____

MENTAL HEALTH:

(circle) ***No Problems***

Psychiatric Condition(s) (circle) **YES NO** If "Yes, type _____
Anxiety (circle) **YES NO**
Depression (circle) **YES NO**

COMMUNICATION

(circle) ***No Problems***

Language Spoken _____
Do you need an interpreter (circle) **YES NO**

VISION

(circle) ***No Problems***

Glasses (circle) **YES NO**
Contacts (circle) **YES NO**
Cataracts _____

Specific problem(s)_____

HEARING

(circle) ***No Problems***

Hearing Aid(s) (circle) **YES NO**
(circle) 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 (circle) Insulin Medication Diet
Thyroid (circle) **YES NO**
Other gland problems _____

RESPIRATORY

(circle) ***No Problems***

Smoker (circle) **YES NO**
If yes, how many per day? _____ How many years have you smoked? _____

Quit smoking? When? _____ How many years did you smoke? _____

Asthma (circle) **YES NO**
Bronchitis (circle) **YES NO**
Pneumonia (circle) **YES NO** **Last episode:** _____
Frequent colds (circle) **YES NO** **Last episode:** _____
Chronic Lung Disease (circle) **YES NO**
Sleep Apnea (circle) **YES NO**

NAME: _____

RESPIRATORY (continued)

Using CPAP machine (circle) **YES NO**
Shortness of breath with exertion (circle) **YES NO**

CARDIAC

(circle) ***No Problems***

High blood pressure (circle) **YES NO**
Low blood pressure (circle) **YES NO**
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**
Angina (circle) **YES NO**
Heart Attack (circle) **YES NO** Year: _____
Pacemaker (circle) **YES NO** Year: _____
Internal defibrillator (circle) **YES NO** Year: _____
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**
History of blood clots (circle) **YES NO** Year _____
Blood clotting disorder (circle) **YES NO**
Swelling (circle) **YES NO** Hands Feet Ankles
History of bleeding problems (circle) **YES NO** If "Yes", what type _____
History of bleeding problems within family (circle) **YES NO** If "Yes", what type _____

REPRODUCTIVE

Female:

Are you pregnant? (circle) **YES NO**
Possible? (circle) **YES NO**
Total # of pregnancies _____
Living _____ Deceased _____ Miscarriage(s) _____ Abortions _____
Last menstrual period _____
Birth Control (circle) **YES NO**
Menopause (circle) **YES NO**

Male: Prostate problems (circle) **YES NO**

GASTROINTESTINAL:

(circle) ***No Problems***

Denture(s) (circle) **UPPER LOWER**

NAME: _____

Partial(s) (circle) **UPPER LOWER**
Bridge(s) (circle) **UPPER LOWER**
Excessive Thirst: □ (circle) **YES NO**
Vomiting (circle) **YES NO** Frequency _____
Difficulty swallowing (circle) **YES NO**
Sudden Weight Loss (circle) **YES NO**
Indigestion (circle) **YES NO**
Heartburn (circle) **YES NO**
Stomach Ulcers □ (circle) **YES NO**
Reflux (circle) **YES NO**
Diarrhea (circle) **YES NO**
Blood in stools (circle) **YES NO**
Diverticulosis (circle) **YES NO**
Irritable bowel (circle) **YES NO**
Constipation (circle) **YES NO**
Bowel pattern - times/day _____

Current weight: _____ lbs Current height: _____ ft' _____in"

URINARY (circle) *No Problems*

Bladder infection(s) (circle) **YES NO** Last episode: _____
Incontinence (circle) **YES NO**
Kidney disease (circle) **YES NO**
Diagnosis _____

Dialysis (circle) **YES NO** Hemodialysis Peritoneal

LIVER

Cirrhosis (circle) **YES NO**
Hepatitis (circle) **YES NO**
Jaundice (circle) **YES NO**

MUSCULOSKELETAL (circle) *No Problems*

Joint/muscle problems (circle) **YES NO** Implants: _____

Chronic Pain (circle) **YES NO**
Describe _____

Ambulatory Aids
i.e. cane, walker (circle) **YES NO**
Describe _____

SKIN: (circle) *No Problems*

NAME: _____

Skin rashes/eczema (circle) **YES NO**
Psoriasis (circle) **YES NO**
Where _____

ANY OTHER MEDICAL CONDITION(S) i.e. Cancer: (circle) **YES NO**

Describe_____

_____

REVIEWED PRE-OPERATIVELY BY _____**, RN**

DATE: _____