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. Return your completed questionnaire as soon as possible by either:

- **Fax:** 807 – 468 - 6794;
- **Email:** preopclinic@lwdh.on.ca;
- **In Person:** drop off to the Pre-Op Clinic (2nd floor at LWDH)
- **Mail to:** Surgical Services Pre-Op Clinic, c/o Lake of the Woods District Hospital, 21 Sylvan Street West, Kenora, Ontario P9N 3W7

For any questions, please call the Pre-Op Clinic at: 807-468-9861 ext 2459.

Surgeon: _____

Procedure: _____

PATIENT ASSESSMENT QUESTIONNAIRE (please fill out all sections)

1. **Today's Date** (date you are completing this form) _____

2. **Your Demographic Information**

   Last Name _____ First Name _____

   Alternate Named Used _____ Preferred Pronoun _____

3. **Your Contact Information**

   Cellphone # Other #

4. **Communication** Check if No Problems

   Primary Language _____ Secondary Language _____

   Do you need an interpreter? ☐ Yes ☐ No

5. Who is picking you up from the hospital on the day of your surgery?

Last Name _____ First Name _____

Cellphone # _____ Other # _____

Notes: _____

6.* Support Person *(spouse, friend, family member)

Do you have a support person/care partner that you would like to be involved in your pre-operative and post-operative care plan? ☐ Yes ☐ No

Last Name _____ First Name _____

Cellphone # _____ Other # _____

7. Primary Care Provider

Family Physician _____ ☐ No Family Physician

Clinic Name _____ Phone # _____

8. Current Height and Weight

Current **height**: ____ft ____in" Current **weight**:_____pounds

9. Surgeries

Surgery	Year	Surgery	Year

10. Anesthesia History

Have you had problems in the past with anesthesia? ☐ Yes ☐ No ☐ Unsure

If yes, please describe problem _____

Blood relatives with anesthesia problems? ☐ Yes ☐ No ☐ Unsure

11. Allergies

☐ None ☐ Environmental ☐ Tape ☐ Latex ☐ Medications

Allergy	Reaction

12. Medication History

List all present medications, including prescription, over the counter, vitamins & herbs

Medication Name	Dosage	How Many Times a Day

13. Mental Health ☐ Check if No Problems

Psychiatric Condition(s) ☐ Yes ☐ No Type _____

Anxiety ☐ Yes ☐ No Depression ☐ Yes ☐ No

14. Vision ☐ Check if No Problems

Glasses ☐ Yes ☐ No Contacts ☐ Yes ☐ No

Cataracts ☐ Yes ☐ No Other _____

15. Hearing ☐ Check if No Problems

Hearing Aide(s) ☐ Yes ☐ No → ☐ Left ☐ Right ☐ I do not wear them

Other _____

16. Dental ☐ Check if No Problems

Dentures ☐ Yes ☐ No → ☐ Upper ☐ Lower ☐ I do not wear them

Partial/Bridge ☐ Yes ☐ No → ☐ Upper ☐ Lower ☐ I do not wear them

17. Neurological ☐ Check if No Problems

History of Stroke/TIA ☐ Yes ☐ No Deficits _____

Migraines ☐ Yes ☐ No Last Episode _____

Seizures ☐ Yes ☐ No Last Episode _____

18. Endocrine ☐ Check if No Problems

Diabetes ☐ Yes ☐ No Controlled With_____

Thyroid ☐ Yes ☐ No Controlled With_____

Other gland problem(s) ☐ Yes ☐ No Controlled With_____
If yes, list _____

19. Marijuana/Cannabis/Alcohol History

Do you currently use marijuana or consume **cannabis**? ☐ Yes ☐ No

If yes, indicate amount and frequency per week _____/ week

Do you currently drink **alcohol**? ☐ Yes ☐ No

If yes, indicate amount and frequency per week _____/ week

20. Illicit Drugs History

Do you currently use or consume **illicit drugs**? ☐ Yes ☐ No

If yes, indicate drug name and frequency per week.

Drug Name_____frequency_____/ week

Drug Name_____frequency_____/ week

Drug Name_____frequency_____/ week

21. Respiratory ☐ Check if No Problems

Are you a tobacco **smoker**? ☐ Yes ☐ No

How many cigarettes per day _____How many years have you smoked?_____

Have you **quit smoking**? ☐ Yes ☐ No

What year did you quit? _____ How many years did you smoke?_____

Asthma	☐ Yes	☐ No	
Bronchitis	☐ Yes	☐ No	
Pneumonia	☐ Yes	☐ No	Last Episode _____
Frequent Colds	☐ Yes	☐ No	Last Episode _____
Chronic Lung Disease	☐ Yes	☐ No	
Sleep Apnea	☐ Yes	☐ No	
Using CPAP machine	☐ Yes	☐ No	
Shortness of Breath with exertion	☐ Yes	☐ No	

22. Cardiac ☐ Check if No Problems

High blood pressure	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Heart valve problems	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Irregular heartbeats	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Internal Defibrillator	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No Year: _____

23. Circulation ☐ Check if No Problems

Numbness	☐ Yes	☐ No
Tingling	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
History of Blood Clots	☐ Yes	☐ No
Blood Clotting Disorder	☐ Yes	☐ No
Swelling	☐ Yes	☐ No
History of Bleeding Problems	☐ Yes	☐ No If yes, what type _____

Family History of Bleeding Problems ☐ Yes ☐ No

If yes, what type _____

24. Reproductive ☐ Check if No Problems

Females

Are you pregnant or possibly pregnant? ☐ Yes ☐ No

Total # of pregnancies _____

Total # living _____ deceased _____ miscarriage _____ abortion _____

Date of last menstrual period _____

Birth Control? ☐ Yes ☐ No Menopause? ☐ Yes ☐ No

Males

Prostate issues? ☐ Yes ☐ No

25. Gastrointestinal ☐ Check if No Problems

Excessive Thirst	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Difficulty Swallowing	☐ Yes	☐ No
Sudden Weight Loss	☐ Yes	☐ No
Indigestion	☐ Yes	☐ No
Heartburn/Acid Reflux	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Blood in Stools	☐ Yes	☐ No
Diverticulosis	☐ Yes	☐ No
Irritable Bowel	☐ Yes	☐ No

Bowel pattern _____ times/day

26. Urinary ☐ Check if No Problems

Bladder Infection	☐ Yes	☐ No	Last episode: _____
Incontinence	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	Diagnosis: _____

Dialysis ☐ Yes ☐ No → ☐ Hemodialysis ☐ Peritoneal

27. Liver ☐ Check if No Problems

Cirrhosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No

28. Musculoskeletal ☐ Check if No Problems

Joint/Muscle Issues	☐ Yes	☐ No	Implants _____
Chronic Pain	☐ Yes	☐ No	Describe _____
Ambulatory Aids	☐ Yes	☐ No	e.g., cane, walker

29. Skin ☐ Check if No Problems

Skin rashes/eczema ☐ Yes ☐ No
Psoriasis ☐ Yes ☐ No Where _____

30. Other Medical Conditions ☐ Check if None

Describe _____

_____

31. Spirituality and Culture Needs

Are there any spiritual practices or cultural considerations we should be aware of prior to your surgical visit?

Describe _____

Notes: _____

Hospital Use Only

Reviewed by Preoperative Clinic Nurse

Name (printed clearly)_____

Signature _____

Date _____

Our Communities Our Hospital
LAKE OF THE WOODS DISTRICT HOSPITAL