Lake of the Woods District Hospital

SURGICAL SERVICES
PATIENT ASSESSMENT QUESTIONNAIRE
PEDIATRICS

Hello:

The purpose of this questionnaire is to assist Surgical Services in creating a positive and safe surgical experience.

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 _____

   Date of Birth _____

3. **Patient lives with:** ☐ Parents ☐ Guardian ☐ In Care

   Last Name _____ First Name _____

   Cellphone # _____ Other Phone # _____

   Notes: _____

4. **Patient Contact Information** ☐ N/A

   Cellphone #_____ Other # _____

5. Current Height and Weight

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

6. Primary Care Provider

Family Physician _____ ☐ No Family Physician

Clinic Name _____ Phone # _____

7. Communicable Diseases **Check if No Problems**

Red Measles ☐ Yes ☐ No Chicken Pox ☐ Yes ☐ No

Pertussis ☐ Yes ☐ No German Measles ☐ Yes ☐ No

8. Surgeries

Surgery	Year	Surgery	Year

9. Anesthesia History

Have there been problems in the past with anesthesia? ☐ Yes ☐ No ☐ Unsure

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

If yes to either question, please describe problem _____

10. Allergies

☐ None ☐ Environmental ☐ Tape ☐ Latex ☐ Medications

Allergy	Reaction

11. Medication History

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

Medication Name	Dosage	How Many Times a Day

12. Marijuana/Cannabis/Alcohol History

Do you use marijuana or consume **cannabis**? ☐ Yes ☐ No
If yes, indicate amount and frequency per week _____/week

Do you drink **alcohol**? ☐ Yes ☐ No
If yes, indicate amount and frequency per week _____/week

13. Mental Health ☐ Check if No Problems

Psychiatric Condition(s) ☐ Yes ☐ No Type _____

Anxiety ☐ Yes ☐ No Depression ☐ Yes ☐ No

14. Communication ☐ Check if No Problems

Primary Language _____ Secondary Language _____

Do you need an **interpreter**? ☐ Yes ☐ No

15. Vision Glasses ☐ Check if No Problems

Yes ☐ ☐ No Contacts ☐ Yes ☐ No

Other _____

16. Hearing ☐ Check if No Problems

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

Other _____

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. 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

When 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	

20. Cardiac ☐ Check if No Problems

Heart murmur	☐ Yes	☐ No	
Heart valve problems	☐ Yes	☐ No	
Rheumatic fever	☐ Yes	☐ No	
Irregular heartbeats	☐ Yes	☐ No	
Palpitations	☐ Yes	☐ No	
Heart Surgery	☐ Yes	☐ No	Year: _____

21. 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 _____

22. 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

23. Gastrointestinal ☐ Check if No Problems

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

Bowel pattern _____ times/day

24. Urinary ☐ Check if No Problems

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

Dialysis ☐ Yes ☐ No ☐ Hemodialysis ☐ Peritoneal

25. Liver ☐ Check if No Problems

Hepatitis	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No

26. Musculoskeletal ☐ Check if No Problems

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

27. Skin ☐ Check if No Problems

Skin rashes/eczema	☐ Yes	☐ No	
Diaper rash	☐ Yes	☐ No	
Skin rashes/eczema	☐ Yes	☐ No	
Psoriasis	☐ Yes	☐ No	Where _____
Sensitive Skin	☐ Yes	☐ No	Where _____

28. Other Medical Conditions ☐ Check if None

Describe _____

_____

29. Spirituality and Culture Needs

Are there any spiritual practices or cultural considerations we should be aware of prior to your surgical visit? ☐ Yes ☐ No

Describe _____

Hospital Use Only

Reviewed by Preoperative Clinic Nurse

Name (printed clearly)_____

Signature _____

Date _____

Our Communities Our Hospital
LAKE OF THE WOODS DISTRICT HOSPITAL