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 INORMATION:

NAME: (Last) _____

(Given) _____

(Used) _____

CONTACT PHONE #: _____ CELLPHONE #_____

ALTERNATE PHONE # & NAME: _____

DATE OF BIRTH: _____ SEX: □ F □ M

FAMILY PHYSICIAN: _____

LANGUAGE UNDERSTOOD: _____

SURGERIES (List all surgeries you have had):

SURGERY	YEAR (if known)

Are you aware of any problems you have had in the past with anesthesia?
□ Yes, what type _____ □ No
Do you have any blood relatives with anesthesia problems? □ Yes □ No

ALLERGIES:

□ 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 & TIME

Do you take street drugs? □ Yes □ No
Type & how taken: _____

Do you use alcohol? □ Yes, how much & frequency _____ □ No

MENTAL HEALTH: □□ No Problems

Psychiatric Condition(s): □□ Yes □□ No If "Yes, type _____

Anxiety: □□ Yes □□ No

Depression: □□ Yes □□ No

COMMUNICATION: □□ No Problems

Language Spoken: _____

Need an interpreter □□ Yes □□ No

VISION: □□ No Problems

Glasses: □□ Yes □□ No

Contacts: □□ Yes □□ No

Cataracts: _____

Specific problem(s): _____

HEARING: □□ No Problems

Hearing Aid(s): □□ Yes □□ No

□□ Left □□ Right □□ Both □□ Don't wear

NEUROLOGICAL: □□ No Problems

History of stroke/TIA: □□ Yes □□ No Deficit(s): _____

Migraines: □□ Yes □□ No Last episode: _____

Seizures: □□ Yes □□ No Last episode: _____

ENDOCRINE: □□ No Problems

Diabetes: □□ Yes □□ No

Controlled with: □ □ Insulin □ Medication □□ Diet

Thyroid: □□ Yes □□ No

Other gland problems: _____

RESPIRATORY: □□ No Problems

Smoker: □□ Yes □□ No

If YES: How many/day? _____ How long/how many years? _____

If quit smoking: When? _____ Smoked for how many years? _____

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

CARDIAC:

☐☐ 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 heart beats: ☐☐ Yes ☐☐ No
Palpitations: ☐☐ Yes ☐☐ No
Angina: ☐☐ Yes ☐☐ No
Heart Attack: ☐☐ Yes ☐☐ No Year: _____
Pacemaker ☐ ☐ Yes ☐☐ No Year: _____
Internal defibrillator: ☐☐ Yes ☐☐ No Year: _____
Heart Surgery: ☐☐ Yes ☐☐ No Year: _____

CIRCULATION:

☐☐ No Problems

Numbness: ☐ ☐ Yes ☐☐ No ☐☐ Hands ☐☐ Feet
Tingling: ☐☐ Yes ☐☐ No ☐☐ Hands ☐☐ Feet
Bruise easily: ☐☐ Yes ☐☐ No
Anemia: ☐☐ Yes ☐☐ No
HIV/AIDS: ☐☐ Yes ☐☐ No
History of blood clots: ☐ ☐ Yes ☐☐ No Year: _____
Blood clotting disorder: ☐☐ Yes ☐☐ No
Swelling: ☐☐ Yes ☐☐ No ☐ Hands ☐☐ Feet ☐☐ Ankles
History of bleeding problems ☐☐ Yes ☐☐ No If "Yes", what type _____
History of bleeding problems within family ☐ ☐ Yes ☐☐ No If "Yes", what type _____

REPRODUCTIVE:

Female:

Are you pregnant? ☐☐ Yes ☐☐ No
Possible? ☐☐ Yes ☐☐ No
Total # of pregnancies:_____: _____
Living/_____Deceased/_____Miscarriage(s)/ _____Abortions
Last menstrual period: _____
Birth Control: ☐☐ Yes ☐☐ No
Menopause: ☐☐ Yes ☐☐ No

***Male*:**

Prostate problems ☐☐ Yes ☐☐ No

GASTROINTESTINAL: □□ No Problems

Denture(s): □ □ Upper □□ Lower
Partial(s): □□ Upper □□ Lower
Bridge(s): □□ Upper □□ Lower
Excessive Thirst: □ □ Yes □□ No
Vomiting: □□ Yes □□ No Frequency: _____
Difficulty swallowing: □□ Yes □□ No
Sudden Weight Loss □□ Yes □□ No
Indigestion: □ □ Yes □□ No
Heartburn: □□ Yes □□ No
Stomach Ulcers: □ □ Yes □□ No
Reflux: □□ Yes □□ No
Diarrhea: □□ Yes □□ No
Blood in stools: □□ Yes □□ No
Diverticulosis: □□ Yes □□ No
Irritable bowel: □□ Yes □□ No
Constipation: □□ Yes □□ No
Bowel pattern: times/day: _____

Current weight: _____lbs Current height: _____

URINARY: □□ No Problems

Bladder infection(s): □□ Yes □□ No Last episode: _____
Incontinence: □□ Yes □□ No
Kidney disease: □□ Yes □□ No
Diagnosis: _____
Dialysis: □□ Hemodialysis □ Peritoneal

LIVER:

Cirrhosis: □□ Yes □□ No
Hepatitis: □□ Yes □□ No
Jaundice: □□ Yes □□ No

MUSCOLSKELETAL: □□ No Problems

Joint/Muscle problems: □ □ Yes □□ No □ Implants: _____
Chronic Pain: □□ Yes □□ No
Describe: _____
Ambulatory Aids
i.e. cane, walker: □ □ Yes □□ No
Describe: _____

SKIN: □□ No Problems

Skin rashes/ Eczema/
Psoriasis: □□ Yes □□ No
Where: _____

Any other medical condition(s) i.e. Cancer: □□ Yes □□ No
Describe: _____

_____

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