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: _____ SEX: □ F □ M

LIVES WITH: □ PARENT(S) □ Yes □ No
□ GUARDIAN □ □ Yes □ No
NAME: _____ Phone # _____
□ IN CARE □ Yes □ No
Alternate #'s: _____

FAMILY PHYSICIAN: _____

LANGUAGE UNDERSTOOD: _____

HEALTH STATE:

IMMUNIZATION HISTORY: DPTP – _____ MMR - _____
Any other immunizations? □ Yes □ No

COMMUNICABLE DISEASES:

Red Measles	□ Yes	□ No
Chicken Pox	□ Yes	□ No
Pertusses	□ Yes	□ No
German Measles	□ Yes	□ No

SURGERIES (List all surgeries you have had): □ None

SURGERY	YEAR

Are there any problems in the past with anesthesia? □□ Yes □ No
Type: _____

Any blood relatives with anesthesia problems? □□ Yes □ No
Type: _____

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

Do you use street drugs? □ Yes □ No Type: _____
Do you use alcohol? □ Yes □ No
If YES: How much?/How often? _____

MENTAL HEALTH: ☐☐ **No Problems**

Psychiatric Condition(s): ☐☐ Yes ☐☐ No

_____

Anxiety: ☐☐ Yes ☐☐ No

Depression: ☐☐ Yes ☐☐ No

COMMUNICATION: ☐☐ No Problems

Language Barrier: _____

Need an interpreter ☐☐ Yes ☐☐ No

VISION: ☐☐ No Problems

Glasses: ☐☐ Yes ☐☐ No

Contacts: ☐☐ Yes ☐☐ No

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? _____

RSV: ☐☐ Yes ☐☐ No

Cystic Fibrosis: ☐☐ Yes ☐☐ No

Asthma: ☐☐ Yes ☐☐ No

Bronchitis: ☐ ☐ Yes ☐☐ No

Pneumonia: ☐☐ Yes ☐☐ No **Last episode:** _____

Frequent colds: ☐☐ Yes ☐☐ No **Last episode:** _____

Sleep Apnea: ☐☐ Yes ☐☐ No

Using CPAP machine ☐☐ Yes ☐☐ No

Shortness of breath ☐☐ Yes ☐☐ No

CARDIAC: ☐☐ 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: _____

CIRCULATION: ☐☐ No Problems

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

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

GASTROINTESTINAL: ☐☐ No Problems

Difficulty swallowing: ☐☐ Yes ☐☐ No
Excessive Thirst: ☐ ☐ Yes ☐☐ No
Vomiting: ☐☐ Yes ☐☐ No Frequency: _____
Sudden Weight Loss ☐☐ Yes ☐☐ No
Indigestion: ☐ ☐ Yes ☐☐ No
Heartburn: ☐☐ Yes ☐☐ No
Reflux: ☐☐ Yes ☐☐ No
Diarrhea: ☐☐ Yes ☐☐ No Frequency: _____
Blood in stools: ☐☐ Yes ☐☐ No Frequency: _____

Diverticulosis: ☐☐ Yes ☐☐ No
Irritable bowel: ☐☐ Yes ☐☐ No
Constipation: ☐☐ Yes ☐☐ No
Diaper: ☐☐ Yes ☐☐ No
Toilet trained: ☐☐ Yes ☐☐ No
Bowel pattern: times/day: _____

Current weight: _____lbs.
Current height: _____

URINARY: ☐☐ No Problems
Bladder infection(s): ☐☐ Yes ☐☐ No Last episode: _____
Kidney disease: ☐☐ Yes ☐☐ No
Diagnosis: _____

LIVER:
Hepatitis: ☐☐ Yes ☐☐ No
Jaundice: ☐☐ Yes ☐☐ No

MUSCOLSKELETAL: ☐☐ No Problems
Weakness: ☐☐ Yes ☐☐ No
Upper body: ☐☐ Yes ☐☐ No
Lower body: ☐☐ Yes ☐☐ No
Joint/Muscle problems: ☐ ☐ Yes ☐☐ No
Chronic Pain: ☐☐ Yes ☐☐ No
Describe: _____
Ambulatory Aids
i.e. cane, walker: ☐☐ Yes ☐☐ No
Describe: _____

SKIN: ☐☐ No Problems
Skin rashes: ☐☐ Yes ☐☐ No
Diaper rash: ☐☐ Yes ☐☐ No
Eczema: ☐☐ Yes ☐☐ No
Psoriasis: ☐☐ Yes ☐☐ No
Sensitive skin:
Where: _____

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

_____

REVIEWED PRE-OPERATIVELY BY: _____, RN