The Ottawa Hospital | L'Hôpital d'Ottawa

PRE-OP HEALTH HISTORY PATIENT QUESTIONNAIRE

Dear Patient: Please complete this health history questionnaire to the best of your ability and give it to your surgeon's office team. If you are not sure of any answer, check "not sure". You can add details in the "Comments" box.

Name	☎ Home	Cell

Email address:	Preferred language: ❑ English ❑ French ❑ Other (specify):	Date of birth (yyyy/mm/dd)	❑ Male ❑ Female

Height: feet/inches or cm	**Weight:** lbs or kgs	For office use only **BMI**

Family Physician ☎

HEART

Do you have:	Yes	No	Not sure	Comments	
1. Any heart problem? (e.g., heart attack, murmur, angina, blockages, angioplasty, stent, valve problems, irregular heartbeat, heart surgery, heart failure).				*Specify:*	*
2. High blood pressure or take medication for high blood pressure?					
3. Chest pain or breathlessness after climbing 1 flights of stairs?					*
4. A pacemaker or an implantable defibrillator?					*
5. Do you take Aspirin (ASA) regularly?				*Why?*	
6. A prescription for blood thinners? (e.g., warfarin, coumadin, plavix, dabigatran, rivaroxaban)					*
7. An artificial heart valve?					*
8. Any other heart issues?				*Specify:*	

BREATHING

Do you have:	Yes	No	Not sure	Comments	
9 a. Have you smoked tobacco of any kind in the past? Please indicate which (e.g., cigarettes, cigars, pipes, marijuana).				number /day: number of years:	
9 b. Have you quit smoking?				*When?*	
10. Emphysema, chronic obstructive pulmonary disease (COPD) or chronic bronchitis?					*
11 a. Asthma?					
11 b. Asthma needing your relief medication more than twice per week or oral steroids in the last 2 months?					*
12. Do you use inhalers (puffers)?				*How often?*	

BREATHING

	Yes	No	Not sure	Comments	
13. Do you use oxygen at home to help you breathe?					*
14. A problem lying flat for at least 30 minutes because of difficulty breathing?					*
15. Have you had shortness of breath for which you have been admitted to hospital within the last 2 months?					*
16. Have you had pneumonia in the past 2 months?					*
17 a. Sleep apnea and use a machine to help you sleep?					
17 b. Have you been told to use a machine to help you breathe at night but choose not to use it?					*
18. Do you have any other breathing issues?					

BLOOD PROBLEMS

Have you ever been treated for:	Yes	No	Not sure	Comments	
19. Sickle cell anemia?					*
20. Anemia (low blood count)?					
21. A bleeding disease or problem?				*Specify:*	*
22. Have you had a blood transfusion within the last 3 months?					
23. Do you have any personal or religious reasons for refusing to have any blood products given to you?					*

NEUROLOGICAL

Do you have/have you had:	Yes	No	Not sure	Comments	
24. Significant memory problems or dementia?					*
25. A history of extreme confusion after an operation?					*
26. A disease that affects your muscles and nerves?					*
27. A stroke or mini-stroke/TIA?					*
28. An aneurysm?					
29. Epilepsy or convulsions?					
More than two months ago:					
In the last two months:					*
30. Fainting spells in the last year?					*

OTHER IMPORTANT MEDICAL INFORMATION

	Yes	No	Not sure	Comments	
31. Have you or your family (blood relatives) had serious problems following an anesthetic other than nausea or vomiting (e.g., malignant hyperthermia)?				*Specify:*	*
32. Do you have trouble opening your mouth, jaw or moving your neck up or down?					*

OTHER IMPORTANT MEDICAL INFORMATION

	Yes	No	Not sure	Comments	
33. Do you take narcotics (like codeine, morphine, HYDROmorpONE, Percocet) for chronic pain?					*
34. Are you pregnant?					*
35. Is there a possibility that you could be pregnant?					
36. Are you diabetic?				❑ on insulin	*
				❑ on diabetic pills	
				❑ diet controlled	
37. Are you on dialysis?					*
38. Do you have kidney disease?					*
39. Do you have thyroid disease?				❑ not well controlled	*
				❑ well controlled	
40. Do you have a urinary tract infection?					
41. Have you had an infection requiring isolation in the hospital?					
42. Do you currently have a cold, chest infection or fever?					*
43. Are you HIV positive?				❑ not on treatment	*
				❑ on treatment	
44. Do you have liver disease?					*
45. Have you had an organ transplant (other than cornea)?					*
46. Do you have stomach ulcers, heartburn or a hiatus hernia?					
47. Do you have arthritis?				❑ rheumatoid arthritis	*
				❑ osteoarthitis	
48. Do you have an autoimmune disease? (e.g., lupus)					*
49. Do you have or have you had cancer?				*Where?*	
50 a. Have you had radiation treatment?				❑ to the head or neck	*
				❑ other:	
51. Male patients: On average do you drink more than 3 alcoholic drinks per day, or 21 drinks per week?				*Total per week:*	*
Female patients: On average do you drink more than 2 alcoholic drinks per day, or 14 drinks per week?					*
52. Do you use any street drugs other than marijuana?					*
53. Do you have a hearing impairment or wear a hearing aid?					

ALLERGIES

Do you have allergies to:	Yes	No	Not sure	Comments	
54. Latex?					
55. Eggs?					
56. Other food?					
57. Medication?				*Name?*	
58. Metal?					
59. Anything else?					

DISCHARGE PLANNING AND MOBILITY

	Yes	No	Not sure	Comments	
60. Do you use a wheelchair, walker, cane, scooter or other aid?					
61. Do you have problems with your balance?					
62. Have you had a fall in the last 3 months?					*
63. When discharged, do you have a responsible adult to drive you home following your surgery?					
64. Do you have someone available to stay with you overnight and help care for you?					
65. Do you presently receive services from home care? (CCAC)					
66. Do you live in a retirement home, boarding home or long term care facility, or other?				*Specify:*	
67. Do you live more than 100 km away from The Ottawa Hospital?					
68. Do you **have to** climb stairs when you are at home?				*How many?*	

LIST ANY SURGERIES OR MINOR PROCEDURES USING ANESTHETIC YOU HAVE HAD IN THE PAST.

Procedure	Year	Procedure	Year
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

LIST ANY OTHER UPCOMING PROCEDURES (other than your surgery) AND WHEN THEY ARE SCHEDULED?

Procedure	Month/Year	Procedure	Month/Year
1.		5.	
2.		6.	
3.		7.	
4.		8.	

INDICATE PHARMACY NAME AND TELEPHONE NUMBER	
Your pharmacy name:	Phone number (or location of pharmacy) ( )

LIST ALL OF THE MEDICATIONS THAT YOU TAKE (INCLUDING HERBAL MEDICATION, VITAMINS, AND NON PRESCRIPTION DRUGS). ATTACH LIST IF NECESSARY.	
1.	13.
2.	14.
3.	15.
4.	16.
5.	17.
6.	18.
7.	19.
8.	20.
9.	21.
10.	22.
11.	23.
12.	24.

Do you have any other illness, limitations or any other concerns we should know about? ❑ Yes ❑ No
Specify:

Patient Health History Questionnaire completed by:

❑ Patient ❑ Family Member ❑ Health Care Provider ❑ Other (specify):

Print name(s)	Signature	Date (yyyy/mm/dd)	Time

IMPORTANT: Please remember to let your surgeon know if you think you are getting a cold, flu or illness or if you start taking any new medications.

Thank you!

For OFFICE use ONLY.

Notes:

Printed name	Signature	Date (yyyy/mm/dd)	Time

For Surgeon's Administrative use ONLY.

Scheduled procedure: _____

Scheduled procedure date: Date (yyyy/mm/dd) _____ Campus: ❑ Civic ❑ General ❑ Riverside

Surgeon: _____ Department: _____ Office telephone: _____

Office contact name: _____ Signature: _____ Office fax: _____

Additional comments:

For Pre-Admission Unit (PAU) use ONLY.

Pre-Admission Unit Appointment Type:

❑ RN Assessment (clinic visit) ❑ RN Telephone ❑ Telemedicine (RN only) ❑ Chart Review

❑ Anesthesia/RN Assessment (clinic visit) ❑ Telemedicine (Anesthesia/RN) ❑ Telemedicine (Anesthesia only)

❑ Other (specify):

Patient Questionnaire Reviewed by: ❑ Pre-Admission Unit RN ❑ Other

Notes:

Printed name(s)	Signature	Date (yyyy/mm/dd)	Time