Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | *À l'écoute de notre santé*

WRHA SURGERY PROGRAM
PREoperative Assessment
Patient Questionnaire

DATE COMPLETED (DD/MMM/YYYY): _____
PHIN: _____

Please fill out this form (questions 1 - 33) to help our Health Care Team meet your medical needs.
Print your answers in black ink; you will need to mail or drop off your completed form to your surgeon's office.
This information is needed at least 3 weeks before your surgery date.

1. Legal Name: _____ (SURNAME) _____ (MIDDLE) _____ (FIRST) _____ (PREFERRED NAME)
2. How old are you? _____
3. Home #: _____ Cell #: _____ Alternate #: _____
4. Date of Surgery (DD/MMM/YYYY) _____ Surgeon's Name: _____
   Type of Surgery: _____
5. Do you have a Health Care Directive? ☐ No ☐ Yes ☐ Copy attached
   Power of Attorney: _____ Phone #: _____
6. a) What language do you speak/understand? ☐ English ☐ French ☐ Other _____
   b) Will you need an interpreter? ☐ No ☐ Yes
7. Contact Person: _____ Relationship: _____ Phone #: _____
   Alternate #: _____
8. Who will pick you up from the hospital on discharge?
   Name: _____ Relationship: _____ Phone #: _____
   Alternate #: _____
9. a) Have you been hospitalized for more than 24 hours or spent more than 24 hours in an Emergency Department in the past 6 months:
   ☐ In an acute care hospital outside Manitoba ☐ In an acute care hospital within Winnipeg
   b) Have you been hospitalized or investigated for the following in the past 6 months?
   ☐ Tuberculosis (TB) ☐ *C. difficile* ☐ MRSA
   ☐ Other Describe: _____ ☐ Do not know
10. Do you have Allergies and/or intolerances (i.e. medication, latex, tape,dust/pollen,food,etc.)
    ☐ No ☐ Yes List below:

Allergic to:	**Reaction:**

11. Do you wear a **Medic Alert® Bracelet** . . . . . ☐ No ☐ Yes
    What does it say? _____
12. List Home Medications or attach a copy of your medication list. ☐ Copy attached
    - Prescription medications (i.e. birth control pills, creams, eye drops, inhalers, insulins, patches, sleeping pills, etc.)
    - Over the counter medications (i.e. aspirins, cold/allergy drugs, laxatives, vitamins)
    - Herbs or others (i.e. garlic, gingko biloba, St. John's Wort)

Drug Name	**Dose** (grams or mg)	**How Often**	**Reason**

If coming to the PREoperative Assessment Clinic, please bring the containers of all prescription and over the counter medications with you.

Hospital Use Only

Interview Information

T _____ **P** _____ **RR** _____

☐ Right Arm
BP _____ ☐ Left Arm

O_2 SATS _____

Weight _____ **Height** _____

BMI _____

☐ **Surveillance swab sent (if indicated)**

☐ Medication Reconciliation Completed for Same Day Admission

☐ Best Possible Medication History Completed for Day Surgery Patient with Chronic Renal Failure on Hemodialysis

Patient Name: _____ **PHIN:** _____

13. Family Doctor's Name: _____ Phone #: _____
Date of last visit: (DD/MMM/YYYY) _____ Reason: _____

14. Do you see a Specialist Doctor (heart, lung, blood, etc.) ☐ No ☐ Yes
List below:
Doctor's Name: _____ Phone #: _____
Date of last visit: (DD/MMM/YYYY) _____ Reason: _____
Doctor's Name: _____ Phone #: _____
Date of last visit: (DD/MMM/YYYY) _____ Reason: _____

15. Is it possible that you could be pregnant? . . . . . ☐ No ☐ Yes

16. How tall are you? _____ How much do you weigh? _____ lbs or kgs

17. a) Do you have Obstructive Sleep Apnea (OSA)? . . . . . ☐ No ☐ Yes
b) Have you had a sleep study? . . . . . ☐ No ☐ Yes
c) Do you use a CPAP/BiPAP machine? . . . . . ☐ No ☐ Yes
d) Do you snore loudly (loud enough to be heard through closed doors)? . . . ☐ No ☐ Yes
e) Do you think you have abnormal or excessive sleepiness during the day? . . ☐ No ☐ Yes
f) Has anyone noticed that you momentarily stop breathing during your sleep? . . ☐ No ☐ Yes
g) Is your neck measurement greater than 40 cm/16 inches? . . . . . ☐ No ☐ Yes

18. a) Do you get short of breath or tightness in your chest lying flat in bed or getting dressed? . . . . . ☐ No ☐ Yes
b) Can you climb 1 flight of stairs without stopping to rest? . . . . . ☐ No ☐ Yes ☐ Haven't tried this activity

19. Health History: Place a mark (X) if you have had any of these ☐ None

- ☐ Chest Pain
- ☐ Angina/Heart Related Chest Pain
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart beats fast, Skipped Beats
- ☐ Rheumatic fever
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Persistant swelling in legs and/or feet
- ☐ Lung Problems
- ☐ Shortness of Breath, Cough, Wheeze
- ☐ Asthma
- ☐ Home Oxygen
- ☐ Stroke
- ☐ Transient Ischemic Attack (TIA)/Mini-stroke
- ☐ Migraines/Headaches
- ☐ Blackouts/Fainting spells in last year
- ☐ Seizures
- ☐ Recent Memory Loss
- ☐ Disease of Nervous System (i.e. MS)
- ☐ Parkinson's Disease/ Tremors
- ☐ Muscle Disease
- ☐ Joint/Bone Problems (i.e. Arthritis)
- ☐ Chronic Pain
- ☐ Gout
- ☐ Frequent Heart Burn/Acid Reflux
- ☐ Ulcers
- ☐ Open Wounds
- ☐ Skin/Rashes
- ☐ Hepatitis/Jaundice/Liver Disease
- ☐ Bowel Disease (i.e. Crohn's Colitis)
- ☐ Kidney/Bladder Problems
- ☐ Hemodialysis
  Date of Next Treatment: _____ (DD/MMM/YYYY)
- ☐ Peritoneal Dialysis
  Date of Next Treatment: _____ (DD/MMM/YYYY)
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Anemia/Low Iron
- ☐ Blood Transfusion
  Date: _____ (DD/MMM/YYYY)
- ☐ Bleeding Disorders
- ☐ Sickle Cell Disease
- ☐ Blood Clots (legs, lungs, pelvis)
- ☐ Family History of Blood Clots
- ☐ Glaucoma
- ☐ Thyroid problems
- ☐ Mental Health Issues
- ☐ Dementia
- ☐ Depression
- ☐ Anxiety/Panic Attacks
- ☐ Malignant Hyperthermia
- ☐ Pseudocholinesterase Deficiency
- ☐ Implanted Electronic Devices (i.e. pacemaker, internal defibrillator, internal pain stimulator)
  Date of Last Visit: _____ (DD/MMM/YYYY)
- ☐ Other

Hospital Use Only

Interview Information

☐ Known OSA (PAC referral required)

☐ High Clinical Suspicion (PAC referral required)

☐ Low Clinical Suspicion

Patient Name: _____ **PHIN:** _____

Comments: _____

_____

Are there health problems that run in your family?
Explain: _____

Have you ever had an anesthetic? . . . . . ☐ No ☐ Yes
Have you ever had a problem with the anesthetic? . . . . . ☐ No ☐ Yes
Explain: _____
Has anyone in your family ever had a problem with an anesthetic? . . . . . ☐ No ☐ Yes
Explain: _____

_____

20. List any Operations you have had:

Operation	Date (DD/MMM/YYYY)	Hospital

The last time that you had surgery, did you experience confusion, hallucination or behaviour that was unusual for you? . . . . . ☐ No ☐ Yes ⚑

21. Have you been admitted to hospital for any reason other than for surgery:

Reason	Date (DD/MMM/YYYY)	Hospital

The last time that you were hospitalized, did you experience confusion, hallucination or behaviour that was unusual for you? . . . . . ☐ No ☐ Yes ⚑

22. List any special tests you have had:
☐ Stress Test ☐ Ultrasound ☐ Angiogram ☐ Other

Test	Date (DD/MMM/YYYY)	Hospital

23. Transfusion History:
a) Do you have a rare blood type or been told that you have antibodies? . . . . ☐ No ☐ Yes
b) Do you object to blood and blood product transfusion for any reason? . . . . ☐ No ☐ Yes
c) Have you ever received blood or blood products? . . . . . ☐ No ☐ Yes
d) Did you have any problems? . . . . . ☐ No ☐ Yes

24. Do you smoke? . . . . . ☐ No ☐ Yes Do you Vaporize? . . . . . ☐ No ☐ Yes
How many per day? _____ Number of years smoked/vaporized? _____
When did you quit _____

25. Do you drink beer/wine/liquor? ⚑ . . . . . ☐ No ☐ Yes
How much? _____ How often? _____

26. Do you use recreational drugs? . . . . . ☐ No ☐ Yes
Type _____ How often? _____

Hospital Use Only

Interview Information

Mini-Cog Score (if available):
_____ ☐ Not Available

⚑ **For patients greater than 65 years of age, flag at risk for delirium if:**
- ☐ **greater than 80 years of age**
- ☐ **benzodiazipines and/or alcohol greater than 3 x/week**
- ☐ **glasses and/or hearing aides**
- ☐ **Mini Mental Status Exam less than 24 or previous delirium**
- ☐ **assistance with any activities of daily living**

Delirium Risk Flags:
_____/5

⚑ **If 2 (two) or more flags are present, implement facility protocol.**

☐ N/A patient less than 65 years of age

Patient Name: _____ **PHIN:** _____

27. Do you have: ☐ Capped or Loose Teeth
☐ Dentures/Removable Teeth or Bridge Work ☐ Upper ☐ Lower
☐ Contact Lenses ☐ Hearing Aid ⚑ ☐ Right ☐ Left
☐ Eyeglasses ⚑ ☐ Body Piercings _____
Prosthesis specify _____

28. Nutrition Status: ☐ Regular Diet
a) Special diet? . . . . . ☐ No ☐ Yes
Type of diet _____
Describe eating pattern: _____
b) Difficulty eating or swallowing? . . . . . ☐ No ☐ Yes
c) Weight pattern? ☐ Stable ☐ Gain ☐ Loss Amount: _____ Time period: _____
☐ Nausea ☐ Vomiting ☐ Choking ☐ Indigestion ☐ Reflux ☐ Anorexia

29. Elimination Status: ☐ Regular ☐ Ostomy ☐ No Concerns
a) Urinary pattern? ☐ Urgency ☐ Incontinent ☐ Frequency ☐ Get up During the Night
Describe urinary pattern: _____
b) Bowel pattern? ☐ Diarrhea ☐ Constipation ☐ Incontinent
Describe bowel pattern: _____
c) Other? . . . . . ☐ No ☐ Yes
Describe: _____

30. Functional Status: ☐ No Concerns
a) Any changes in activities of daily living: . . . . . ☐ No ☐ Yes
Explain: _____

For the Day Surgery Population, ***if one or more of the risk for falls questions [30(b)(c) or (d)] is checked yes, initiate facility falls prevention screening tool***

b) Falls within 12 months: . . . . . ☐ No ☐ Yes
c) Do you require assistance with toileting, bathing, dressing, walking, feeding: . . . . . ☐ No ☐ Yes ⚑
Explain: _____
d) Do you use any of these: ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair
☐ Scooter ☐ Mechanical Lifts ☐ Bathroom Assists
Explain: _____

e) Any changes in sleep pattern: . . . . . ☐ No ☐ Yes
Explain: _____
f) Do you have any pain: . . . . . ☐ No ☐ Yes
Explain: _____

31. What are your living arrangements? ☐ No Concerns
a) Lives: ☐ Alone ☐ Spouse/partner ☐ Child(ren) ☐ Pets ☐ Other _____
b) Residence: ☐ Apartment ☐ House ☐ Group Home ☐ Personal Care Home
☐ Supportive Housing ☐ Assisted Living
☐ Other Explain: _____
c) Must use stairs: ☐ No ☐ Yes Number: _____
Is there a railing? ☐ No ☐ Yes

32. Are you using any community services right now? ☐ No Services
☐ Home Care ☐ Physiotherapy ☐ Occupational Therapy
☐ Dietitian ☐ Day Hospital ☐ Lifeline®
☐ Handi-transit ☐ Other
☐ Treaty Number _____ ☐ Band Name: _____
☐ Social Assistance Case Worker Name: _____
Phone# _____ Case # _____

33. Who completed this form? ☐ Patient
☐ Other Name/Relationship: _____

Hospital Use Only

Interview Information

☐ Consults Initiated

☐ Facility Falls Prevention Screening Tool Initiated

Screened by RN: _____

Date (DD/MMM/YYYY)/Time (24 HOUR)

Assessed by RN: _____

Date (DD/MMM/YYYY)/Time (24 HOUR)

Thank you for taking the time to complete this questionnaire.

Patient Questionnaire is valid for 6 months, provided there has been no significant change in the patient's condition.