



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, ginkgo 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 _____

BP _____ Right Arm
 Left Arm

O₂ 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: _____

Hospital Use Only

Interview Information

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

- Known OSA (PAC referral required)
- High Clinical Suspicion (PAC referral required)
- Low Clinical Suspicion

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

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

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: _____

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
 - benzodiazepines 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

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? _____

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 _____

Hospital Use Only

Interview Information

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

Consults Initiated

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: _____

Facility Falls Prevention Screening Tool Initiated

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

Screened by RN: _____

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 # _____

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

Assessed by RN: _____

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

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.