Hamilton Health Sciences

Preoperative Patient Questionnaire - Adult

Patient's Last Name First Name

Address Street

City Province Postal Code

Health Card Number

Patient's Birthdate (yyyy/mm/dd) Age Sex ☐ M ☐ F

Date (yyyy/mm/dd)_____

Surgery_____

Name of person completing this form (if not the patient)_____

Relationship to patient_____

Name patient likes to be called:_____

Previous operations and / or hospital stays	Date (yyyy/mm/dd)	Previous operations and / or hospital stays	Date (yyyy/mm/dd)
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Have you ever had an anesthetic?	☐ No	☐ Yes
Have you had any problems with anesthesia such as unusual temperature changes or trouble breathing?	☐ No	☐ Yes
Do you have a blood relative who has had any problems with anesthesia such as unusual temperature changes or trouble breathing?	☐ No	☐ Yes

Mouth	Do you have any loose teeth, capped teeth, braces or retainers?	☐ No	☐ Yes
	Do you have dentures? ☐ No ☐ Yes → (Upper: ☐ Full ☐ Partial) ☐ Yes → (Lower: ☐ Full ☐ Partial)		
	Do you have difficulty opening your mouth fully?	☐ No	☐ Yes
	Do you have pain or difficulty when you move your neck?	☐ No	☐ Yes
Heart and Stroke	Do you have high blood pressure or do you take medication for high blood pressure?	☐ No	☐ Yes
	Do you have high cholesterol or do you take medication for high cholesterol?	☐ No	☐ Yes
	Have you ever had angina or chest pain?	☐ No	☐ Yes
	Have you ever had a heart attack?	☐ No	☐ Yes
	Have you ever had heart failure?	☐ No	☐ Yes
	Have you ever had an irregular heart beat?	☐ No	☐ Yes
	Do you have a pacemaker or an implantable defibrillator?	☐ No	☐ Yes
	Have you ever had a stroke or a mini stroke?	☐ No	☐ Yes
	Have you ever had a blood clot?	☐ No	☐ Yes
	Can you walk up two flights of stairs without stopping?	☐ No	☐ Yes

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Date: (yyyy/mm/dd)_____

Breathing	Do you currently smoke? ☐ No ☐ Yes → Number of cigarettes a day ___ Number of years ___		
	Have you ever smoked? ☐ No ☐ Yes → When did you quit?_____ Number of cigarettes a day ___ Number of years ___		
	Do you have trouble with your breathing → During exercise? ☐ No ☐ Yes With normal activity? ☐ No ☐ Yes		
	Do you currently have a cough with mucous or sputum?	☐ No	☐ Yes
	Do you use oxygen at home?	☐ No	☐ Yes
	Do you snore loud enough to be heard from another room?	☐ No	☐ Yes
	Have you ever been told that you stop breathing while you are asleep?	☐ No	☐ Yes
	Have you ever been told that you have sleep apnea?	☐ No	☐ Yes
	Do you use a C-Pap or Bi-Pap machine regularly at home?	☐ No	☐ Yes
	Have you ever been told that you have asthma?	☐ No	☐ Yes
	Have you ever been told that you have tuberculosis, emphysema or chronic bronchitis?	☐ No	☐ Yes
Liver / Stomach	Have you ever been jaundiced (yellow colour of your skin)?	☐ No	☐ Yes
	Do you have frequent heartburn?	☐ No	☐ Yes
	Have you ever been told that you have a hiatus hernia?	☐ No	☐ Yes
	Have you ever been told that you have ulcers?	☐ No	☐ Yes
Renal / Endocrine	Do you have kidney disease?	☐ No	☐ Yes
	Do you have diabetes?	☐ No	☐ Yes
	Do you have thyroid problems?	☐ No	☐ Yes
Brain / Nerve	Have you ever been diagnosed with epilepsy, seizures or fainting spells?	☐ No	☐ Yes
	Do you have a disease that affects your muscles or nerves?	☐ No	☐ Yes
	Have you ever been treated for any mental illness?	☐ No	☐ Yes
Blood	Have you ever been told that you have a bleeding disorder?	☐ No	☐ Yes
	Have you ever been anemic or been told you have low iron?	☐ No	☐ Yes
	Have you ever had a blood transfusion?	☐ No	☐ Yes
	Would you have any objection to receiving blood products if necessary?	☐ No	☐ Yes
	Have you arranged with your surgeon's office to donate your own blood for surgery?	☐ No	☐ Yes

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Infectious Disease	Have you ever been told you have HIV or AIDS?	☐ No	☐ Yes
	Have you ever been told you have hepatitis?	☐ No	☐ Yes
Other	Do you take prescription medication for chronic pain?	☐ No	☐ Yes
	Do you drink alcohol? ☐ No ☐ Yes → How many drinks per week		
	Do you use recreational or street drugs?	☐ No	☐ Yes
	Do you have any cultural or religious practices that we should be aware of while you are in the hospital?	☐ No	☐ Yes
Female Patients Only	Could you be pregnant at this time? ☐ No ☐ Yes ☐ N/A		
	Date of last Menstrual period (yyyy/mm/dd)		

What other health issues should we be aware of before your surgery?

Adult Preoperative Patient Questionnaire Reviewed By:

Printed Name	Signature & Designation	(yyyy / mm / dd)
Printed Name	Signature & Designation	(yyyy / mm / dd)
Printed Name	Signature & Designation	(yyyy / mm / dd)

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Pre Surgery Medication List

Patient's Birthdate (yyyy/mm/dd) Age Sex ☐ M ☐ F

Date: (yyyy/mm/dd)_____

Please list all medications you take including: • Prescription - including inhalers (puffers), insulin and patches • Vitamins / Supplements / Diet Pills • Herbal • Over the counter products • Eye / Ear drops • Nasal Mists	**Dose** (Strength)	**How Often Taken**	**When** Morning (am) Afternoon (aft) Evening (eve) Bedtime (pm)

Rx **Please bring all your prescription medication containers and non-prescription medication containers with you to the Pre-Op Clinic**


• including inhalers (puffers) and insulin •