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 #: _____
   Email: _____
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
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 ☐ VRE
   ☐ 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 _____
BP _____ (Right Arm)
_____ (Left Arm)
O_2 SATS _____
Weight _____
Height _____
BMI _____

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

☐ Medication Reconciliation Completed

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. Do any of these things make you feel short of breath or give you tightness in your chest?
Lying flat in bed . . . ☐ No ☐ Yes Climbing 1 flight of stairs. . . . . ☐ No ☐ Yes
Walking 1 block . . . ☐ No ☐ Yes Housework, getting dressed . . . ☐ No ☐ Yes

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

- ☐ Chest Pain
- ☐ Angina
- ☐ 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
- ☐ Falls within 6 months
- ☐ 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 Problems
- ☐ Sickle Cell Disease
- ☐ Blood Clots (legs, lungs, pelvis)
- ☐ 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
- ☐ TEDS
- ☐ Risk for Falls Protocol Initiated

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

How many per day? _____ Number of years smoked? _____

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: _____
b) Do you require assistance with toileting, bathing, dressing, walking, feeding: ☐ No ☐ Yes ⚑
Explain: _____
c) Do you use any of these: ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair ☐ Scooter
☐ Mechanical Lifts ☐ Bathroom Assists
Explain: _____
d) Any changes in sleep pattern: . . . . . ☐ No ☐ Yes
Explain: _____
e) 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 ☐ PCH ☐ 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

Screened by RN:

RN Signature:

Date: (DD/MMM/YYYY)

Assessed by RN:

RN Signature:

Date: (DD/MMM/YYYY)

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.