WOODSTOCK HOSPITAL
Woodstock, ON

REVIEWED BY PATIENT & FAMILY ADVISORY COUNCIL

PRE-OPERATIVE PATIENT QUESTIONNAIRE

PIN NUMBER VISIT NUMBER

PATIENT LAST NAME PATIENT 1ST NAME PATIENT MIDDLE NAME

TELEPHONE

DOB MMM DD YYYY AGE SEX ONT HEALTH CARD NUMBER

FAMILY PHYSICIAN

- You will be asked to leave 2 phone numbers where you could be reached if needed prior to surgery
- You should expect to spend between 30 minutes to 1 hour at your appointment
- Online Surgical Information Video is available on the hospital website – www.woodstockhospital.ca
- Click on Our Services, Surgical Services, then "Your Day of Surgery at Woodstock Hospital" for more information on what to expect and how to prepare for your visit

Please bring the following with you for your pre-operative clinic appointment:

- Completed Pre–Operative Patient Questionnaire
- **ALL MEDICATIONS** in their original containers including prescriptions, over–the–counter medications and herbal medications (eye drops, sprays, inhalers, creams, patches, injections)
- All MedsCheck List (from your Pharmacist) if you have one
- Health card
- Insurance information and interpreter if required

What to expect during your Pre-operative Clinic appointment:

- Please complete the attached Pre–operative Questionnaire ahead of time to inform us about your general health, medical and surgical history, medications, and special considerations regarding your physical, mental and emotional needs. We will ask your weight and measure height. If your doctor has requested any blood work, x–rays or an ECG, these tests will be done as an outpatient.
- You will be given a form by your physician for the testing. Instructions for your surgery day (medication instructions, special equipment such as crutches, etc) will be reviewed with you with emphasis on any instructions specific to your surgery

Please complete the sections of the questionnaire that apply to you

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Procedure: _____

☐ Elective admission on: _____

☐ Same Day surgery on: _____

☐ Daycare surgery on: _____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

Prior to surgery, you are required to have pre–operative tests done.

You have been scheduled for:

☐ **Telephone/Virtual pre–admission visit**

Your phone call will be **Date:** _____ **Time:** _____
(MMM,DD,YYYY)

Please make sure you are at the number you have given your surgeon's office, so the nurse can reach you at the time noted above.

☐ **Anaesthetic consult visit**: **Date:** _____ **Time:** _____
(MMM,DD,YYYY)

Please have available with you all your medications in original containers, including inhalers, eye drops and homeopathic medications.

Note: Please allow a minimum of 30 minutes – 1 hour for appointment.

Woodstock Hospital is a scent free environment. Please do not wear or use any scented products prior to your hospital visit.

If you are unsteady when walking, please bring someone to assist you or request a wheelchair.

QUESTIONS? PLEASE CALL 519–537–2381

YOU MUST BRING YOUR ONTARIO HEALTH CARD FOR EACH VISIT

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Date (mmm,dd,yyyy): _____
Surgery: _____
Person completing form: _____
Height (cm): _____ Weight (kg): _____ Age: _____

General Information

Are you allergic to latex? If yes, describe reaction: _____	☐ Yes	☐ No
Have you been tested for this allergy?	☐ Yes	☐ No
Do you have any allergies to medications?	☐ Yes	☐ No
Medication: _____ Reaction: _____		
Medication: _____ Reaction: _____		
Medication: _____ Reaction: _____		
Medication: _____ Reaction: _____		
Do you have any other allergies?	☐ Yes	☐ No
If yes, list _____		
Have you ever received anesthesia? ☐ General anesthetic ☐ Spinal or epidural ☐ Nerve Block ☐ Sedation	☐ Yes	☐ No
Have you ever had problems with anesthesia?	☐ Yes	☐ No
☐ Malignant hyperthermia ☐ Nausea/vomiting ☐ Pseudocholinesterase deficiency		
☐ Difficult insertion of the anesthesia breathing tube (intubation) ☐ Other		
If yes, describe: _____		
Do you have a relative that has had problems with anesthesia?	☐ Yes	☐ No
☐ Malignant hyperthermia ☐ Pseudocholinesterase deficiency		
If yes,describe: _____		
Do you have any medical problems or specific questions or concerns to discuss with the anesthesiologist? _____ _____ _____	☐ Yes	☐ No
Do you have any loose teeth? If yes, which teeth: _____	☐ Yes	☐ No
Do you have dentures? If yes, what type: _____	☐ Yes	☐ No
Do you have: ☐ veneers ☐ caps ☐ crowns ☐ bridge	☐ Yes	☐ No
Do you smoke or have you ever smoked (including vaping)?	☐ Yes	☐ No
If yes: # of cigarettes/day: _____ # of years smoked: _____ year stopped _____		
Do you use recreational drugs, street drugs or marijuana/cannabis? If yes:	☐ Yes	☐ No
Type: _____ Amount: _____ How often: _____		

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Do you drink alcohol – beer, wine and/or liquor? If yes, # of drinks/week: _____	☐ Yes	☐ No
Have you taken cortisone, prednisone or steroids in the last 3 months?	☐ Yes	☐ No
Have you ever been treated for cancer? If yes, type of cancer:_____ year:_____	☐ Yes	☐ No
Treatment type (ie chemo, radiation):_____		
Could you be pregnant? Date of last menstrual period: _____	☐ Yes	☐ No

Surgical History

Previous surgeries –please list.

Surgery:_____ Year _____
Surgery:_____ Year _____
Surgery:_____ Year _____
Surgery:_____ Year _____
Surgery:_____ Year _____

Respiratory

Have you ever been diagnosed with any of the following? ☐ Asthma ☐ Tuberculosis ☐ Emphysema ☐ COPD ☐ Pneumonia ☐ Other breathing/lung problems:_____	☐ Yes	☐ No
Do you see a Respirologist? Name:_____ Last visit:_____	☐ Yes	☐ No
Do you have sleep apnea? If yes, do you: ☐ use CPAP ☐ use BiPAP ☐ use neither	☐ Yes	☐ No
Do you snore loudly?	☐ Yes	☐ No
Do you often feel tired, sleepy or fatigued during the day?	☐ Yes	☐ No
Has anyone observed you stop breathing or choke/gasping during sleeping?	☐ Yes	☐ No
Do you have any breathing problems? Describe:_____	☐ Yes	☐ No
Do you use oxygen at home? If yes, how much _____	☐ Yes	☐ No
Have you had a cold/flu or chest infection in the last month?	☐ Yes	☐ No
Do you have a cough with sputum?	☐ Yes	☐ No

Cardiovascular

Have you ever had: ☐ high blood pressure ☐ heart attack ☐ heart murmur ☐ angina (chest pain) ☐ congestive heart failure ☐ irregular heartbeat ☐ heart valve problem ☐ Other heart problems	☐ Yes	☐ No
Do you see a Cardiologist? If yes, Name:_____ Last visit:_____	☐ Yes	☐ No
Have you needed: ☐ heart surgery ☐ surgery on major arteries or veins	☐ Yes	☐ No
Have you had: ☐ stress test ☐ angiogram ☐ echocardiogram (heart ultrasound)	☐ Yes	☐ No
Do you have: ☐ pacemaker ☐ defibrillator ☐ stents ☐ artificial heart valve	☐ Yes	☐ No

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Do you need to stop walking after 2 blocks or less?	☐ Yes	☐ No
Do you need to raise the head of the bed or use more than 1 pillow to sleep?	☐ Yes	☐ No
Do you have problems lying flat for greater than 20 minutes?	☐ Yes	☐ No
Do you have problems with your circulation in your legs?	☐ Yes	☐ No

Gastrointestinal

Have you ever had liver problems such as hepatitis or cirrhosis?	☐ Yes	☐ No
Have you ever been jaundiced (yellow)?	☐ Yes	☐ No
Do you have frequent heartburn (GERD), ulcer(s) or hiatus hernia?	☐ Yes	☐ No
Do you have any problems with your bowels? ☐ constipation ☐ Crohn's disease ☐ Colitis ☐ other: _____	☐ Yes	☐ No

Renal

Have you ever had kidney disease? Describe: _____	☐ Yes	☐ No
Are you a dialysis patient? ☐ Peritoneal ☐ Hemodialysis	☐ Yes	☐ No

Endocrine

Do you have diabetes? ☐ Type 1 ☐ Type 2 ☐ Gestational	☐ Yes	☐ No
How is your diabetes managed? ☐ diet ☐ oral medications ☐ insulin ☐ insulin pump	☐ Yes	☐ No
Do you have thyroid disease? ☐ hyperthyroidism ☐ hypothyroidism ☐ other _____	☐ Yes	☐ No
Do you have any autoimmune disorders? If yes, describe: _____	☐ Yes	☐ No

Neurological / Musculoskeletal

Have you ever had: ☐ stroke (CVA) ☐ mini–stroke (TIA) ☐ seizures If yes, when was your last episode? _____	☐ Yes	☐ No
Do you have: ☐ multiple sclerosis ☐ Parkinson´s ☐ Alzheimer´s ☐ memory problems ☐ other neurologic or muscle disorders: _____	☐ Yes	☐ No
Have you had any injuries to your back, spine or joints? If yes, describe: _____	☐ Yes	☐ No
Do you experience: ☐ numbness ☐ tingling ☐ arm weakness ☐ leg weakness Describe: _____	☐ Yes	☐ No
Do you have arthritis? If yes, ☐ osteoarthritis ☐ rheumatoid arthritis ☐ other: _____	☐ Yes	☐ No
Do you have osteoporosis?	☐ Yes	☐ No

Hematological

Have you ever been diagnosed with: ☐ bleeding disorder ☐ anemia ☐ sickle cell disease ☐ low blood iron ☐ thalassemia ☐ low platelets ☐ other: _____	☐ Yes	☐ No

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Have you ever had a blood clot in your ☐ legs or ☐ lungs? If yes, year: _____	☐ Yes	☐ No
Have you taken blood thinner medications in the last month? If yes, name: _____	☐ Yes	☐ No
Have you recently stopped taking a blood thinner? If yes, when did you stop? _____	☐ Yes	☐ No
Have you ever received a blood transfusion or blood products? When _____	☐ Yes	☐ No
Have you ever experienced a reaction to blood products?	☐ Yes	☐ No
Do you have any personal or religious reasons for not accepting blood products	☐ Yes	☐ No
Skin		
Do you have problems with your skin? ☐ rash ☐ ulcer/open area ☐ eczema ☐ psoriasis If yes, describe: _____	☐ Yes	☐ No
Mental Health		
Have you ever been treated for: ☐ anxiety ☐ depression ☐ bipolar disease ☐ psychosis ☐ obsessive compulsive disorder ☐ PTSD ☐ schizophrenia personality disorder ☐ other mental health problem or addiction: _____	☐ Yes	☐ No
Are you currently being treated for mental health illness or addictions?	☐ Yes	☐ No
Special accommodations		
Do you require the use of an interpreter? Describe: _____	☐ Yes	☐ No
Do you have normal vision without glasses or lenses? If no: ☐ wear glasses all the time ☐ wear reading glasses ☐ wear contacts	☐ Yes	☐ No
Do you have normal hearing without the use of hearing aids? If no: ☐ left hearing aid ☐ right hearing aid ☐ both hearing aids ☐ deaf	☐ Yes	☐ No
Do you have difficulty with any of the following activities? ☐ bathing yourself ☐ dressing yourself ☐ feeding yourself ☐ grooming yourself	☐ Yes	☐ No
Do you use any assistive devices? ☐ cane ☐ crutches ☐ walker ☐ wheelchair ☐ other: _____	☐ Yes	☐ No
Living arrangements		
Do you live alone? If no, ☐ spouse or significant other ☐ child ☐ friend ☐ other:		
Where do you live? ☐ house or apartment ☐ retirement home ☐ long term care home ☐ group home / assisted living ☐ homeless ☐ other: _____ Do you use any support services? If yes, which services: _____	☐ Yes	☐ No
Do you have a responsible adult to stay with you on the night of your surgery if you are being discharged home the same day as your surgery? Name: _____	☐ Yes	☐ No
Other Considerations		
Do you have any religious or cultural practices that you would like us to know about? If yes, describe: _____	☐ Yes	☐ No
Do you have an Advanced Directive or a Power of Attorney for personal care? If yes, describe: _____	☐ Yes	☐ No
Is there anything else we need to know about you to assist you during your hospital stay? If yes, describe: _____		

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Medication and Supplements: Bring all your current medications in their original containers and/or an up–to–date list of medications from your pharmacist. Include both prescription and over–the–counter medications, inhalers, creams, vitamins, and herbal supplements. Attach your list or record your medications below.

Name	Dose	How often taken	Reason for taking