Covenant Health
Banff Mineral Springs

PRE-OPERATIVE PATIENT QUESTIONNAIRE

Office Use Only

MSH# IF APPLICABLE____________________

All information gathered will be kept confidential.

LEGAL NAME:________________________________ E-MAIL ADDRESS:____________________

AGE: __________ WEIGHT:______________ lb/kg ***(CIRCLE ONE)*** HEIGHT: __________ ft/cm ***(CIRCLE ONE)***

BMI: ___________ (CALCULATED BY OFFICE)

FAMILY DR/CLINIC/LOCATION:____________________________ FAMILY DR PHONE# ____________________

THIS SECTION IS FOR OFFICE USE ONLY

Surgeon: Date Seen: **OR Date:**

Procedure:

	CBC	Gluc	Bun/Creat	Lytes	EKG	LFT	TSH	HgAIC
Required								
Ordered								
Received								

Orders:

Comments:

Anaesthetic Review Date: OK to Book-NO PAC ☐ Date:

OK to Book: YES ☐ NO ☐ ASA 1 ☐ ASA 2 ☐ Surgeon Signature:

OK to Book w RESTRICTIONS: ☐ **(Red Pen)**

Name:

Please fill out this questionnaire and hand it back to your Surgeon's medical office assistant. A copy will be sent to the hospital if you are booked for surgery to assist the physicians and nurses there who will be looking after you. It will remain a confidential part of your medical chart and will only be seen by those people involved in your care. ***Failure to provide details as requested may delay your surgery.***

Do you have-- Or-- have you ever had any of the following: (check off boxes in either the No or Yes column)	**No**	**Yes**	**If-- YES, --it is *EXTREMELY IMPORTANT* to provide details in the space below. (i.e. Year of Event, Details of Event, Where Treated, Tests Done)**
Stroke (paralysis, weakness, numbness, visual problems on one side of your body)			
Epilepsy ☐ **Seizures** ☐ **Blackouts** ☐ ***Check all that apply**			
Severe Chest Pain ☐ **Angina** ☐ **Heart Attack** ☐ **Heart Failure** ☐ ***Check all that apply**			
Heart Surgery ☐ **Pacemaker** ☐ **Angioplasty** ☐ **Stent** ☐ **Blood Thinners** ☐ ***Check all that apply**			
Heart Murmur ☐ **Heart Valve problems** ☐ ***Check all that apply**			If yes, are antibiotics required prior to dental procedures? No ☐ Yes ☐
High Blood Pressure			
Irregular Heart Beat ☐ **Palpitations** ☐ **Requiring Blood Thinners** ☐ ***Check all that apply**			
Shortness of breath when Walking ☐ **Climbing Hills** ☐ **Climbing one flight of stairs** ☐ ***Check all that apply**			
What exercise do you do? What is your activity level?			
Asthma ☐ ***If yes-please complete the questionnaire pg 4*** **Emphysema** ☐ **COPD** ☐ ***Check all that apply**			
ICU admissions ☐ example = serious illnesses ☐ tracheotomies ☐ injuries ☐ ***check all that apply**			
Snore ☐ * **Sleep Apnea** ☐ ***(If yes, complete the questionnaire pg 5)*** *C-Pap machine ☐ Mouth Guard ☐ No treatment ☐			
Heartburn ☐ **Acid Reflux** ☐ **Stomach Ulcers** ☐ **Hiatus Hernia** ☐ ***Check all that apply**			
Diabetes **Type I** ☐ **Type II** ☐ Insulin Dependent ☐ Tablet ☐ Diet Controlled ☐			
Kidney ☐ **Bladder** ☐ **Prostate problems** ☐ ***Check all that apply**			
Liver problems ☐ **Jaundice/Hepatitis** ☐			
Difficulty opening your mouth ☐ **Moving your neck** ☐ ***Check all that apply**			
Dentures ☐ **Capped Teeth** ☐ **Loose Teeth** ☐ **Bridges** ☐ ***Check all that apply**			
Serious problems/reactions to Anaesthetic Yourself ☐ Immediate family ☐ ****provide full details****			
Arthritis: Rheumatoid ☐ **Osteo** ☐ **Lupus** ☐			
Multiple Sclerosis			
Thyroid Disorder Now ☐ History of ☐			
Varicose Veins			
Pregnant			
Bleeding Disorders Yourself ☐ Immediate family ☐ ***Check all that apply** * ***provide full details****			
Blood Clots: Legs ☐ **Lungs** ☐ ***Check all that apply** Yourself ☐ Immediate family ☐ ****provide full details****			
Illnesses or Medical Problems that were not mentioned ****provide full details****			

Name:

Have you ever had any of the following?	No	Yes	Please provide ALL details so Results can be Obtained	
Exercise Stress Test (Treadmill)			Year, Reason:	Lab & City:
Nuclear Medicine Heart Scan (MIBI)			Year, Reason:	Lab & City:
Heart Catheterization (angiogram)			Year, Reason:	Lab & City:
Heart Echocardiogram (ultrasound of heart)			Year, Reason:	Lab & City:
Holter Monitor			Year, Reason:	Lab & City:
EKG			Year, Reason:	Lab & City:
Lung Function test/pulmonary function test			Year, Reason:	Lab & City:
Sleep Apnea Test			Year, Reason:	Lab & City:

Have you ever seen a:	No	Yes	Please provide ALL details so Results can be Obtained
Cardiologist			Year: Dr, Clinic, City: Reason:
Respirologist			Year: Dr, Clinic, City: Reason:
Neurologist			Year: Dr, Clinic, City: Reason:
Other			Year: Dr, Clinic, City: Reason:

List ALL Previous Surgery / **Previous Surgery**

Name of Surgery	Anaesthetic Used (Genera/Spinal/IV Sedation/Local)	Problems with Anaesthetic	Year	Hospital/Clinic	City/Prov.

Do you take any MEDICATIONS? **YES** ☐ **NO** ☐

Please list the **name** and **dosage** of **ALL MEDICATIONS** including **prescriptions** or **over the counter pills**, **inhalers**, **patches**, **vitamins** and **herbal supplements** and/or **steroids**.

Drug Name	Dosage (mg, etc.) Amount (1 tab)	How Often Taken (daily, 2 times a day)

Do you have any ALLERGIES? (Please include any food or drug allergies) YES ☐ **NO** ☐

Allergy	Reaction

Are you allergic to latex (rubber)? YES ☐ **NO** ☐ **Reaction:**

Name:

	YES	NO	
Do you **Smoke**?			If YES, How much? ___________ For how long?
Did you used to smoke?			If YES, How much? ___________ For how long? When did you quit?
Do you use recreational drugs?			If YES, please specify:
Do you drink Alcohol?			If YES, How much in a week?

Smoking Questionnaire Please complete if you have any history of smoking!

# of Cigarettes per day:__________________________ How Long:_________________

Chronic Cough:________ How Long: ____________Dry: _______ Productive:_________

Chest Infections and Treatments
(Steroids/Inhalers):____

____

Any Shortness of Breath on Exertion:_______________ Type of Work:____

Can you climb 1 flight of stairs without shortness of Breath: YES: _____________ NO:__________________

Exercise-what can you do____

Asthma Questionnaire Please complete if you have any history of Asthma

Asthma medications: (Inhalers, Steroids, Etc.) dosage, # of times used per day and when:

____

____

Ventolin use: Times used Wkly: _________ or Times Used Mthly_________ Reason for Use:________________________

Asthma Triggers:____

____

Does breathing get worse with: Cold Air: Yes No Dust: Yes No Smoke: Yes No

Difficulty breathing (dyspnoea) at night or in the early morning: Yes No

Hospitalizations due Asthma attack: Yes No **ER visits due to Asthma attack**: Yes No **Recent exacerbations**: Yes No

If Yes-Please provide details:____

____

Have you had a General Anaesthetic with Intubation? Yes No

If yes, any complications?____

Name:

PAC SLEEP APNEA Questionnaire

Please complete if you answered yes to snoring!

(STOP-Bang Snore Model)

	Question		
1.	Snoring: Do you snore loudly (loud enough to be heard through closed doors)?	Yes	No
2.	Tired: Do you often feel tired, fatigued, or sleepy during the daytime?	Yes	No
3.	Observed: Has anyone observed you stop breathing during your sleep?	Yes	No
4.	Blood Pressure: Do you have or are you being treated for high blood pressure?	Yes	No
5.	BMI: BMI more than 35?	Yes	No
6.	Age: Age over 50 years old?	Yes	No
7.	Neck circumference: Neck circumference greater than 40 cm (15 3/4")?	Yes	No
8.	Gender: Male?	Yes	No
		_______	_______
	Total Score:	Yes	No

For Anaesthesia only

High Risk OSA: Yes to 3 or more questions

Low Risk OSA: Yes to less than 3 questions

Name *(last, first)*		
Birthdate *(yyyy-Mon-dd)*		
PHN#	HRN#	CoMIS#

Consent to Disclose Health Information

The patient/client or his/her authorized representative must complete this form before AHS may disclose the patient's/client's health information to someone else *(unless Alberta's Health Information Act authorizes disclosure without consent)*. The information on this form, together with any record authorizing a representativ to act on behalf of the patient/client, is being collected under part 3 of the Health Information Act for the purpose of recording the patient's/client's consent to the specified disclosure and will be filed on the patient/client record. For questions about this collection of information, contact the program area that provided you this form or contact the Chief Privacy Officer at 10301 Southport Lane SW, Calgary, AB T2W 1S7 or call 1.877.476.9874.

Patient/client name			
Date of birth *(yyyy-Mon-dd)*	Personal health number *(authorized by HIA s.21(1))*		
Address	City/Town	Province	Postal Code

Details of health information being disclosed *(write in full without abbreviations, include dates of treatment)*

Identify below where records exist

Health service provider, hospital, clinic, program	City/Town
Date consent is effective *(yyyy-Mon-dd)*	Expiry date *(valid for 2 years if no date)* *(yyyy-Mon-dd)*

Name of individual(s)/organization(s) information is being disclosed to

Phone	Address	City/Town	Province	Postal Code

Purpose(s) of disclosure

Authority of person(s) giving consent *(If signing on behalf of the patient/client, indicate your authority below and provide a copy of the document which authorizes you)*

- ☐ **Guardian (or Trustee)** - of a minor under the age of 18 years, who is not determined to be a mature minor - named in a Guardianship Order/appointed under the Adult Guardianship and Trusteeship Act, if access to health information relates to the powers and duties of the guardian (or trustee)
- ☐ **Nearest relative under Mental Health Act** - if access to health information is necessary to carry out obligations of the nearest relative
- ☐ **Agent** - appointed in an enacted personal directive according to the Personal Directives Act
- ☐ **Personal representative** - of a deceased patient, if the access to information relates to administration of the individual's estate
- ☐ **Power of attorney** - if access to health information relates to the powers and duties of the attorney
- ☐ **Written authorization** - any written authorization from the individual to act on the individual's behalf
- ☐ **Specific decision maker** - as defined in the Adult Guardianship and Trusteeship Act

I authorize AHS to disclose the health information described above to the individual(s) or organization(s) identified above. I understand why I have been asked to disclose my individually identifying information. I am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure of my health information. I understand that I may revoke this consent in writing at any time.

Name of person giving consent	Signature	Date *(yyyy-Mon-dd)*

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