PREOPERATIVE HEALTH HISTORY QUESTIONNAIRE

Dear Patient: Please complete this health history questionnaire the best that you can and return it when complete. If you are not sure of any answer, check "not sure". You can add details in the "Comments" box.

This information will help us work with you and better plan for your care. This may include follow−up testing or taking part in a perioperative anesthesia clinic.

Patient Name:	**Home Phone Number:**	**Cell Phone Number:**
Email Address:	**Date of Birth (YYYY/MON/DD):**	**For Office Use Only:**
Height: _____ (feet/inches) **OR** _____ (cm)	**Weight:** _____ (lb) **OR** _____ (kg)	**BMI:** _____

Family Physician:	**Home Pharmacy:**	**Location of Pharmacy:**

OPERATION HISTORY
What operations have you had in the past? Please include where and when (approximate year) you had the operation.

Procedure	Year	Hospital
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ANESTHETIC HISTORY	**Yes**	**No**	**Not Sure**	**Comments**	
1. Have you had severe nausea (feeling sick to your stomach) or severe vomiting (throwing up) after surgery?	❑	❑	❑		
2. Have you been told that you have a 'difficult airway' or that placing a breathing tube in your airway is difficult?	❑	❑	❑		*
3. Have you or a family member (related by blood) had a serious problem after receiving an anesthetic? **Check all that apply:**	❑	❑	❑		
❑ Malignant hyperthermia (uncommon life−threatening reaction to anesthesia with high temperatures and muscle rigidity)					*
❑ Pseudocholinesterase deficiency (sensitivity to the muscle relaxant Succinylcholine which can be used during general anesthesia)					
❑ Other (specify in comments):					

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DO YOU TAKE ANY MEDICATIONS?		
❑ Yes ❑ No		
If YES, list all of the medications that you take (including herbal medication, vitamins, prescription and non−prescription drugs). ATTACH LIST IF NECESSARY.		
Medication	**Dose**	**When You Take It**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

DO YOU HAVE ANY ALLERGIES?	
❑ Yes ❑ No	
If YES, please list all of your allergies and your reactions.	
Allergic to	**Reaction**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

HEART AND BLOOD VESSELS 1. Do you get:	**Yes**	**No**	**Not Sure**	**Comments**	
Angina (chest discomfort/pressure) or have you been told that you have blockages in your heart?	❑	❑	❑		
Chest pain or heaviness after climbing a flight of stairs or walking two blocks on a flat surface?	❑	❑	❑		*
2. Do you have any of the following:	**Yes**	**No**	**Not Sure**		
A heart murmur?	❑	❑	❑		
Problems with the valves in your heart (tight or leaky valve)?	❑	❑	❑		*
An artificial heart valve?	❑	❑	❑		*
High blood pressure or take medication for high blood pressure?	❑	❑	❑		
A pacemaker or implantable cardiac defibrillator (ICD)?	❑	❑	❑		*

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3. Have you ever had:	Yes	No	Not Sure	Comments	
A heart attack?	❑	❑	❑	**When:**	
A cardiac (heart) angioplasty or stent (procedures to open clogged arteries or improve blood flow)?	❑	❑	❑		*
Congestive heart failure or fluid on your lungs?	❑	❑	❑		*
An irregular heartbeat such as:	❑	❑	❑		
❑ Atrial fibrillation					
❑ SVT (Supraventricular tachycardia)					
❑ WPW (Wolff−Parkinson−White)					
❑ Other (specify in comments)					
Chest pain, shortness of breath, fainting or a near−fainting episode caused by an irregular heartbeat?	❑	❑	❑		*

4. Do you have:	Yes	No	Not Sure	Comments	
Claudication (pain caused by low blood flow) or blockages in the arteries (blood vessels) of your legs (peripheral vascular disease)?	❑	❑	❑		
An aneurysm (specify in comments)?	❑	❑	❑		
Any other heart issues (specify in comments)?	❑	❑	❑		

BREATHING	Yes	No	Not Sure	Comments	
1. Do you need to stop while climbing one flight of stairs or walking two blocks on a flat surface due to shortness of breath?	❑	❑	❑		*
2. Do you have a problem lying flat for over 30 minutes because of difficulty breathing?	❑	❑	❑		
3. Have you smoked tobacco of any kind or vaped in the past? If YES, please indicate which: ❑ Cigarettes ❑ Vaping ❑ Cigars ❑ Other: _____ ❑ Pipes	❑	❑	Amount: _____ Number of years: _____ Have you quit smoking? ❑ Yes ❑ No If YES, when (YYYY/MON): _____		
4. Have you been told that you have emphysema or chronic obstructive pulmonary disease (COPD)?	❑	❑	❑		
5. Do you have asthma?	❑	❑	❑		
	Yes	**No**	**N/A**	**Comments**	
6. If you use inhalers, do you need to take your rescue medication (e.g. Ventolin/Salbutamol) more than twice per week?	❑	❑	❑		*
	Yes	**No**	**Not Sure**	**Comments**	
7. In the past 5 years have you gone to the emergency room, been admitted to hospital, or prescribed a steroid (e.g. prednisone or hydrocortisone) for your breathing?	❑	❑	❑		*
8. Do you use oxygen at home to help you breathe?	❑	❑	❑		*
9. Have you had pneumonia in the past 2 months?	❑	❑	❑		*
10. Have you been diagnosed with, or suspected of having, obstructive sleep apnea?	❑	❑	❑		
If NO: Has anyone observed you choke, gasp, or stop breathing during sleep?	❑	❑	❑		*
If YES: Check what applies to you: ❑ I use my CPAP machine regularly ❑ I do not regularly use a CPAP machine					
11. Do you have any other breathing issues?	❑	❑	❑	**Specify:**	

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GASTROINTESTINAL	Yes	No	Not Sure	Comments	
1. Do you have liver disease (history of jaundice, hepatitis, cirrhosis or cancer in your liver)?	❑	❑	❑		*
2. Do you have a hiatal hernia or significant problems with heartburn (acid reflux)?	❑	❑	❑		
3. Do you have any bowel disease?	❑	❑	❑	**Specify:**	
4. Have you had significant weight loss recently (more than 10% of your body weight) without trying to lose weight?	❑	❑	❑		*
5. Have you been eating less than usual for more than a week?	❑	❑	❑		

BLOOD	Yes	No	Not Sure	Comments	
1. Do you take Aspirin (ASA) regularly (specify in comments)?	❑	❑	❑	**Why:**	
2. Do you use blood thinners other than Aspirin (ASA)? (e.g., warfarin [Coumadin], clopidogrel [Plavix], dabigatran [Pradaxa], rivaroxaban [Xarelto], Apixaban [Eliquis])?	❑	❑	❑		*
3. Have you ever been treated for anemia or low red blood cell counts?	❑	❑	❑		
4. Do you or a family member have a bleeding problem (not related to blood thinners)?	❑	❑	❑		*
5. Do you have any personal or religious reasons for refusing blood products?	❑	❑	❑		*
6. Have you ever had a blood clot in your legs (deep venous thrombosis/DVT) or lungs (pulmonary embolism/PE)?	❑	❑	❑		
7. Do you have any viral blood diseases? (e.g. HIV, Hep B or C)?	❑	❑	❑		*

KIDNEY	Yes	No	Not Sure	Comments	
1. Do you have (or need) an AV fistula, dialysis, or kidney transplant?	❑	❑	❑		*
2. Do you have kidney disease (other than a history of stones) or problems with the function of your kidneys?	❑	❑	❑		

ENDOCRINE	Yes	No	Not Sure	Comments	
1. Do you have diabetes?	❑	❑	❑		
IF YES, check what applies:					
❑ On insulin					*
❑ On diabetic pills					
❑ Diet controlled	**Yes**	**No**	**N/A**		
2. Do you have pituitary or adrenal disease?	❑	❑	❑	**Specify:**	*
3. Do you have thyroid disease?	❑	❑	❑		
If YES, check what applies:				**Comments**	
❑ Not well controlled (having symptoms)					*
❑ Well controlled					

NEURO Do you have:	Yes	No	Not Sure	Comments	
1. Significant memory problems or dementia?	❑	❑	❑		*
2. Parkinson's disease?	❑	❑	❑		*
3. Multiple sclerosis?	❑	❑	❑		*

PREOPERATIVE HEALTH HISTORY QUESTIONNAIRE

NEURO cont'd...	**Yes**	**No**	**Not Sure**	**Comments**	
4. A disease that affects your muscles or nerves (e.g. muscular dystrophy, myasthenia gravis, ALS, etc.)?	❑	❑	❑	**Specify:**	*
5. A history of stroke or mini−stroke/TIA?	❑	❑	❑	**When:**	*
6. A brain aneurysm that has not been treated (by clipping or coiling)?	❑	❑	❑		*
7. An implanted spinal cord or deep brain stimulator?	❑	❑	❑		*
8. Epilepsy, seizure disorder or convulsions?	❑	❑	❑		
IF YES, check what applies:					
❑ Last seizure more than 6 months ago					
❑ Seizure within the past 6 months					*

OTHER	**Yes**	**No**	**Not Sure**	**Comments**	
1. Are you being treated for a mental health condition (e.g. anxiety or depression)?	❑	❑	❑	**Specify:**	
2. Have you ever had an organ transplant (other than cornea)?	❑	❑	❑		*
3. Are you pregnant?	❑	❑	❑		*
4. Do you take opioids (e.g. hydromorphone [Dilaudid], morphine [Statex], fentanyl, codeine, oxycodone) for chronic pain?	❑	❑	❑		*
5. Do you use:	**Yes**	**No**	**Comments:**		
Cannabis (smoking, vaporizing, oils, or edibles)?	❑	❑			
Cocaine?	❑	❑			*
Other street drugs?	❑	❑	**Specify:**		
	Yes	**No**	**Not Sure**	**Comments**	
6. Do you drink more than 3 alcoholic drinks per day (male) or 2 alcoholic drinks per day (female)?	❑	❑	❑		
7. Have you ever had radiation treatment to the head or neck?	❑	❑	❑		*
8. Do you have osteoarthritis (the most common form of arthritis)?	❑	❑	❑		
9. Do you have an autoimmune inflammatory arthritis such as rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis (these are much less common, and you would be managed by a rheumatologist)?	❑	❑	❑		*
10. Do you have other autoimmune diseases (e.g. lupus or scleroderma)?	❑	❑	❑	**Specify:**	*
11. Have you needed steroids (e.g. hydrocortisone, prednisone) in the last year?	❑	❑	❑		

SPECIAL TEST HISTORY FOR HEART AND LUNGS

List any special tests you have had for your heart and lungs (stress test, heart ultrasound [echocardiogram], dye test [angiogram], sleep study, or pulmonary function tests [PFTs]):

Test	**Date** (approximately) (YYYY/MON)	**Hospital**
1.		
2.		
3.		
4.		
5.		

PREOPERATIVE HEALTH HISTORY QUESTIONNAIRE

DISCHARGE PLANNING AND MOBILITY	Yes	No	Not Sure	Comments	
1. Do you use a wheelchair, walker, cane, scooter or other aid?	❑	❑	❑		
2. Do you have a problem with your balance?	❑	❑	❑		
3. Have you had a fall in the last three months?	❑	❑	❑		
4. Do you have a responsible adult to drive you home following your surgery?	❑	❑	❑		
5. Do you have someone available to stay with you overnight and help care for you?	❑	❑	❑		

DO YOU HAVE ANY OTHER ILLNESS, LIMITATIONS OR ANY OTHER CONCERNS WE SHOULD KNOW ABOUT?	Yes ❑	No ❑	Not Sure ❑
Specify:			

PATIENT HEALTH HISTORY QUESTIONNAIRE COMPLETED BY:			
❑ Patient	❑ Family Member	❑ Health Care Provider	❑ Other (please specify):
Name:			**Date Form Completed (YYYY/MON/DD):**

IMPORTANT: Please remember to let your surgeon know if you think you are getting a cold, flu or illness, or if you start taking any new medications.