

# PRE-OPERATIVE PATIENT SELF ASSESSMENT

To be completed by the **Patient** and returned to the Surgeon's office as soon as possible.

PAGE 1 of 3

OFFICE USE ONLY:

Name: \_\_\_\_\_ LAST NAME FIRST NAME

Male  Female

J #: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

OHIP #: \_\_\_\_\_

If you are **GOING HOME THE SAME DAY AFTER YOUR SURGERY**, you **MUST** have a responsible adult to take you home or your surgery will be cancelled. It is also recommended that you have someone stay with you overnight.

## Demographic Information

Patient Name: (Last, First)			Date of Birth (DD-MM-YYYY):	
Phone:	Home:	Work/Cell:	Preferred time of day to contact you:	<input type="checkbox"/> 8:00 am –12:00 pm <input type="checkbox"/> 12:00 pm – 4:00 pm
Preferred Language:	<input type="checkbox"/> English <input type="checkbox"/> Other:		Can we leave you a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Doctor & Contact Number:		Family Doctor Address:		

## Blood Transfusion

Have you ever had a blood transfusion or blood replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Type? (If known):	
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## Do you have any allergies? (Including medications, foods or environment)

ALLERGY	Reaction	ALLERGY	Reaction

## Are you taking any medications? (List all prescribed and non-prescribed medications, including herbal remedies)

MEDICATION (Dose and Frequency)	MEDICATION (Dose and Frequency)

## Additional medication related information:

For medication dosing, please record your **height** \_\_\_\_\_ **AND weight** \_\_\_\_\_

Have you been taking medication for <b>pain</b> routinely in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take <b>aspirin, blood thinners, or anti-coagulants</b> on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you taken <b>oral steroids</b> in the last year? (e.g. Prednisone, Cortisone)	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Name &amp; phone number of current pharmacy:</b>		
Please list any substances or recreational drug use regularly (type and frequency):		
Do you drink Alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes", how many drinks per day?

## Please list all of the surgeries you have had:

Surgery:	Date:	Surgery:	Date:

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Medical History (check all that apply):	
<b>CARDIOVASCULAR</b>	<b>ENDOCRINE</b>
<input type="checkbox"/> Chest Pain or Angina	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Attack	Age of onset: _____
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Take Insulin
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Pacemaker	<b>MUSCULOSKELETAL</b>
<input type="checkbox"/> Clot in Lungs or Legs	<input type="checkbox"/> Arthritis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Joint or Bone Implants (metal/ plastic)
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Back or neck problems
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Rheumatic Fever	Location of pain: _____
<b>RESPIRATORY</b>	<b>NEUROLOGICAL</b>
<input type="checkbox"/> Smoking/ Tobacco Use	<input type="checkbox"/> Head Injury
Number of cigarettes per day: _____	<input type="checkbox"/> Stroke
Number of years smoking: _____	<input type="checkbox"/> Loss of Consciousness
Quit? If so, when? _____	<input type="checkbox"/> Loss of Sensation in Legs or Feet
<input type="checkbox"/> Emphysema or COPD	<input checked="" type="checkbox"/> Shooting Pain Down Arms or Legs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizures/ Epilepsy
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Migraines
<input type="checkbox"/> Recent Cold/Cough (last 2 weeks)	<input type="checkbox"/> Swallowing Difficulty
<input type="checkbox"/> Shortness of Breath (when climbing 1 flight of stairs)	<input type="checkbox"/> Dementia
<b>GASTROINTESTINAL</b>	<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> Gastrointestinal Bleeding	<b>MENTAL HEALTH</b>
<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Anxiety and/ or Depression
<input type="checkbox"/> Liver Cirrhosis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Ulcers	<b>COMMUNICABLE ILLNESS</b>
<input type="checkbox"/> Frequent Nausea or Vomiting	<input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
<input type="checkbox"/> Frequent Heart burn	<input type="checkbox"/> HIV/ AIDS
<input type="checkbox"/> Hiatus Hernia	<b>SENSORY/OTHER</b>
<b>GENITOURINARY</b>	<input type="checkbox"/> Vision Difficulties
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Glasses or Contact Lenses
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Hearing Difficulties
<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Hearing Aid <input type="checkbox"/> Right <input type="checkbox"/> Left
<b>AIRWAY</b>	<b>FAMILY HISTORY</b>
<input type="checkbox"/> Dentures: <input type="checkbox"/> Full <input type="checkbox"/> Partial	<input type="checkbox"/> Malignant Hyperthermia
<input type="checkbox"/> Caps <input type="checkbox"/> Crowns <input type="checkbox"/> Loose Teeth	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Difficulty Moving Head/Neck/Jaw	<input type="checkbox"/> Adverse Reaction to Anaesthetic: _____
<input type="checkbox"/> History of "Difficult Intubation"	<b>FEMALE PATIENTS ONLY</b>
<b>BODY PIERCINGS</b>	<input type="checkbox"/> Do you think you could be pregnant?
<input type="checkbox"/> Location(s): _____	Date of last menstrual period: _____

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Obstructive Sleep Apnea Screening	
Do you have sleep apnea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use CPAP or BiPAP? <span style="float: right;">If yes, setting at?</span>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you snore loudly (loud enough to be heard through a closed door)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you often feel tired, fatigued or sleepy during the daytime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone observed you stop breathing or choking/ gasping during your sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have, or are you being treated for high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Screening for Interest in Tobacco Reduction:	
Have you used tobacco in the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, would you be willing to speak with a health care provider regarding your tobacco use while you are a patient of SJHC?	<input type="checkbox"/> Yes <input type="checkbox"/> No

CAGE Alcohol Screening Test	
In the past year, have you had a drink containing alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If "Yes", please answer the following questions.</b>	
Have you ever felt that you should <u>cut</u> down on your drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have people <u>annoyed</u> you by criticizing your drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever felt bad or <u>guilty</u> about your drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a drink first thing in the morning to steady your nerves or to get rid of a hangover ( <u>eye-opener</u> )?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Give one point to each "Yes" answer to determine your total score.</b>	Total Score: _____
<b>Answer the following question if your Total Score is 2 or greater.</b>	
Are you willing to speak with a health care provider regarding your alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Home Environment (check all that apply):	
In your home do you have:	<input type="checkbox"/> Stairs – number of stairs _____ <input type="checkbox"/> Elevator <input type="checkbox"/> Ramp
What supports do you have at home?	<input type="checkbox"/> Family member/ Friend <input type="checkbox"/> CCAC Services <input type="checkbox"/> Social work <input type="checkbox"/> Other: _____ <input type="checkbox"/> None
Do you require assistance with any of the following?	<input type="checkbox"/> Bathing <input type="checkbox"/> Toileting <input type="checkbox"/> Meals <input type="checkbox"/> Dressing <input type="checkbox"/> Activity (walking) <input type="checkbox"/> Housekeeping
Is there anyone at home who depends on you?	<input type="checkbox"/> Children <input type="checkbox"/> Parents <input type="checkbox"/> Spouse <input type="checkbox"/> Pets <input type="checkbox"/> Other: _____
What is your regular form of transportation?	<input type="checkbox"/> Family <input type="checkbox"/> Self (please indicate method of transportation): _____ <input type="checkbox"/> Wheel-Trans please indicate wheel-Trans #: _____

Discharge Planning and Additional Information	
Has your doctor discussed expected length of stay in the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your doctor discussed plans for going home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a living will/advanced directive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a power of attorney for personal care?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Patient or Guardian: _____	Date: _____
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