WOODSTOCK HOSPITAL
Woodstock, ON

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

PreAdmission Assessment

Information provided by: ☐ Patient ☐ Family, Friend ☐ Interpreter ☐ Other

Interpreter Required? ☐ Yes ☐ No

Pregnant? ☐ No ☐ Unsure ☐ Yes ☐ Attempting to conceive

Last Menstrual Period? _____

Estimated Due Date? _____

Languages Spoken

☐ English ☐ French ☐ Russian
☐ American Sign Language ☐ German ☐ Spanish
☐ Arabic ☐ Italian ☐ Vietnamese
☐ Cantonese ☐ Polish ☐ Other:
☐ Dutch ☐ Portugese

Cultural or Religious Practices affecting care

Current Living Situation

☐ Assisted Living ☐ Home with day care ☐ Law enforcement detention ☐ Other:
☐ Extended care facility ☐ Home with family care ☐ Psychiatric facility
☐ Home independently ☐ Homeless or Shelter ☐ Rehabilitation facility

Physical Assessment

Mobility

☐ Independent ☐ Supervision ☐ Extensive assist ☐ Total dependence
☐ Setup only ☐ Limited assist ☐ Maximal assist ☐ Other:

Assistive Devices

☐ Cane ☐ Gait belt ☐ Slider board ☐ Walker ☐ Other:
☐ Crutches ☐ Mechanical lift ☐ Trapeze ☐ Wheelchair

Dental

☐ Full upper denture ☐ Partial upper plate ☐ Braces (retainers) ☐ No teeth ☐ Bridge ☐ Other:
☐ Full lower denture ☐ Partial lower plate ☐ Crowns (caps) ☐ Loose teeth ☐ Implants

Implanted Devices

☐ Analgesia pump ☐ Insulin pump ☐ Left intra-ocular lens ☐ Pacemaker
☐ Cardioverter Defibrillator ☐ Other medication pump ☐ Right intra-ocular lens ☐ Other:

Prosthetic Devices

☐ Left arm prosthesis ☐ Left breast prosthesis ☐ Left eye prosthesis ☐ Left leg prosthesis ☐ Other:
☐ Right arm prosthesis ☐ Right breast prosthesis ☐ Right eye prosthesis ☐ Right leg prosthesis

Vision

☐ Contact lenses ☐ Glasses ☐ Reading ☐ Distance ☐ Guide dog ☐ White cane
☐ Other:

Both Eyes

☐ Blind ☐ Glaucoma ☐ Night blindness ☐ Retinitis pigmentosa
☐ Cataracts ☐ Legally blind ☐ Stratismus ☐ Other:
☐ Corneal transplant ☐ Macular degeneration ☐ Retinal detachment

LEFT EYE

☐ Blind ☐ Corneal transplant ☐ Glaucoma ☐ Prosthesis ☐ Strabismus
☐ Cataract ☐ Enucleated ☐ Macular degeneration ☐ Retinal detachment ☐ Other:

RIGHT EYE

☐ Blind ☐ Corneal transplant ☐ Glaucoma ☐ Prosthesis ☐ Strabismus
☐ Cataract ☐ Enucleated ☐ Macular degeneration ☐ Retinal detachment ☐ Other:

Hearing Loss

☐ Deaf ☐ Right ear ☐ Left ear ☐ Other:

Hearing Aids Prosthesis

☐ Hearing aid, left ☐ Cochlear implant, left ☐ Augmented telephone ☐ Other:
☐ Hearing aid, right ☐ Cochlear implant, right ☐ Pressure equalizing tubes

Other

Taken cortisone or prednisone within the last year ☐ Yes ☐ No
Received chemo or radiation for cancer ☐ Yes ☐ No

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	Have you ever had:	Yes	No
Cardiovascular Peripheral Vascular	Abdominal Aortic Aneurysm		
	Angina, Chest Pain		
	Arrhythmia, irregular heart beat		
	Cardiomegaly, enlarged heart		
	Congenital Heart Abnormality		
	Congestive Heart Failure		
	Coronary Artery Disease		
	Heart Murmur		
	Heart Valve Disease		
	Hyperlipidemia (medication for high cholesterol)		
	Hypertension (medication for high blood pressure)		
	Myocardial Infarction, heart attack		
	Peripheral Vascular Disease (varicose veins, swelling feet)		
	Have you ever had a blood clot in your leg?		
	Other Known Medical History (any problems in the past):		
Respiratory	Asthma		
	COPD		
	Emphysema		
	Do you have a cough with mucous, sputum or phlegm		
	Chronic bronchitis		
	Reactive Airway Disease		
	Sleep Apnea, excessive snoring (use of C-pap)		
	Tuberculosis		
	Have you used medication (puffers) for your breathing in the last 6 months		
	Home oxygen		
	Have you ever had a blood clot in your lungs		
	Other Known Medical History (smoker, pneumonia):		
Neurological	Brain Aneurysm		
	Brain Tumour		
	CVA Stroke		
	Dementia or alzheimers		
	Headaches or migraines		
	Head Injury or concussions		
	Multiple Sclerosis		
	Parkinson Disease		
	Seizure Disorder, Epilepsy		
	Syncope, fainting, dizzy spells		
	Transient Ischemic Attacks (mini stroke)		
	Other Known Medical History (any problems in the past):		

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	Have you ever had:	Yes	No
Gastrointestinal	Bowel Disease		
	Crohn's, Ulcerative Colitis		
	Diverticular Disease		
	Gallbladder Surgery		
	Heartburn, acid reflux		
	Hernia		
	Irritable Bowel Syndrome		
	Liver Disease		
	Pancreatic Disease		
	Ulcers (Stomach)		
	Have you ever been jaundiced		
	Other Known Medical History (any diet restrictions):		
Genitourinary Reproduction	Bladder Disease, surgery, bladder infections		
	Breast Disease (lumpectomy, mastectomy)		
	Cervical Disease		
	Menstrual Problems		
	Ovarian Disease		
	Penile Disease		
	Prostate Disease		
	Kidney stones		
	Kidney Disease		
	Sexually Transmitted Infection		
	Testicular Disease		
	Uterine Disease		
	Other Known Medical History:		
Musculoskeletal	Back Injury		
	Bone Disease		
	Chronic Back Pain		
	Fibromyalgia (wide spread musculoskeletal pain, tenderness, fatigue)		
	Arthritis		
	Osteoporosis, Osteopenia (reduced bone mass), bone density		
	Rheumatoid Arthrithis		
	Other Known Medical History:		

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	Have you ever had:	Yes	No
Mental Heath	Attention Deficit Hyperactivity Disorder, Learning Disability		
	Anxiety		
	Autism Spectrum Disorder		
	Bipolar Disorder		
	Borderline Personality Disorder		
	Depression		
	Eating Disorder		
	Intellectual Delay		
	Obsessive Compulsive Disorder		
	Panic Attacks		
	Psychosis		
	Schizophrenia		
	Substance Abuse		
	Other Known Medical History:		
Metabolic	Adrenal Disease		
	Diabetes Type I		
	Diabetes Type II		
	Gestational Diabetes		
	Metabolic Syndrome		
	Pre-Diabetes		
	Thyroid (on medication or had thyroid surgery)		
	Other Known Medical History:		
Eye Ear Nose Throat	Head, Neck (any limited movement)		
	Dental Disease (dentures, broken teeth etc)		
	Epistaxis (nose bleeds)		
	Other Known Medical History:		

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	Have you ever had:	Yes	No
Infections	Chicken pox, shingles		
	HIV, AIDS		
Immune System	Hepatitis		
	Herpes		
	Measles		
	Mumps		
	Rubella (German measles)		
	Other Known Medical History:		
Integumentary	Eczema, Psoriasis		
	Skin problems ie rosacea		
	Skin Ulcers		
	Other Known Medical History:		
Other Medical	Anemia (low iron)		
	Chronic Fatigue Syndrome		
	Leukemia		
Conditions	Lymphoma		
	Vitamin B12 Deficiency		
	Sickle Cell		
	Have you ever been diagnosed with a bleeding disorder		
	Other Known Medical History:		
Alcohol	Alcohol Use -if Yes ☐ Current ☐ Past ☐ Mild ☐ Moderate ☐ Daily		
Tobacco	Tobacco Use-if Yes ☐ Current ☐ Within the past year ☐ More than 1 year ago		
Drug Use	Recreational Drug use If Yes -Type: ☐ Current ☐ Past ☐ Declined to state		
Resuscitation	Do you have an Advance Directive (DNR, Living Will, Power of Attorney Personal Care)		

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Previous Anesthesia, Surgery	Have you had problems with anesthesia ☐ Yes ☐ No If yes, reaction was: ☐ Awareness ☐ Excessive post-op nausea ☐ Malignant Hyperthermia ☐ Cardiac arrest ☐ Hypertension ☐ Other:
	Has a family member had a problem with anesthesia ☐ Yes ☐ No If yes, reaction was: ☐ Awareness ☐ Excessive post-op nausea ☐ Malignant Hyperthermia ☐ Cardiac arrest ☐ Hypertension ☐ Other:
	List previous surgeries:
Transfusion	Blood transfusion ☐ Yes ☐ No If yes, how long ago? _____ Any problems ☐ Yes ☐ No If yes, please list:

Date: _____ **Patient Signature:** _____